EFFECTIVENESS OF BEHAVIOUR CHANGE COMMUNICATION PROGRAMME ON AWARENESS OF HIGH RISK BEHAVIOUR AMONG ADOLESCENT BOYS IN SELECTED SCHOOL AT KANCHIPURAM DISTRICT

By

Mr. S.KARTHIK

A Dissertation submitted to
THE TAMILNADU Dr. M.G.R MEDICAL UNIVERSITY,
CHENNAI.

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

APRIL- 2012

CERTIFIED THAT THIS IS A BONAFIDE WORK OF

Mr.S.KARTHIK

ADHIPARASAKTHI COLLEGE OF NURSING
MELMARUVATHUR - 603 319.

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING FOR THE TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY, CHENNAI - 600032.

COLLEGE SEAL:

SIGNATURE : _____

Dr.N.KOKILAVANI, M.Sc(N).,M.A(Pub.Admn).,M.Phil.,Ph.D.,
PRINCIPAL,
ADHIPARASAKTHI COLLEGE OF NURSING,
MELMARUVATHUR – 603 319,
KANCHIPURAM DISTRICT,
TAMIL NADU.

EFFECTIVENESS OF BEHAVIOUR CHANGE COMMUNICATION PROGRAMME ON AWARENESS OF HIGH RISK BEHAVIOUR AMONG ADOLESCENT BOYS IN SELECTED SCHOOL AT KANCHIPURAM DISTRICT

By

Mr. S.KARTHIK

M.Sc., (Nursing) Degree Examination,

Branch – V, Psychiatric Nursing,

Adhiparasakthi College of Nursing,

Melmaruvathur – 603 319.

A Dissertation submitted to

THE TAMIL NADU Dr. M.G.R. MEDICAL UNIVERSITY,

CHENNAI.

IN PARTIAL FULFILMENT OF THE REQUIRMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

APRIL – 2012

EFFECTIVENESS OF BEHAVIOUR CHANGE COMMUNICATION PROGRAMME ON AWARENESS OF HIGH RISK BEHAVIOUR AMONG ADOLESCENT BOYS IN SELECTED SCHOOL AT KANCHIPURAM DISTRICT

APPROVED BY DISSERTATION COMMITTEE

April – 2012

Signature..……..
Dr. N. KOKILAVANI, M.Sc(N).,Ph.D.,
PRINCIPAL AND HEAD OF THE DEPARTMENT – RESEARCH,
ADHIPARASAKTHI COLLEGE OF NURSING,
MELMARUVATHUR - 603 319.

Signature ……
Prof. B.SHEEBA, M.Sc(N)., M.Phil.,
HEAD OF THE DEPARTMENT OF PSYCHIATRIC NURSING,
ADHIPARASAKTHI COLLEGE OF NURSING,
MELMARUVATHUR - 603 319.

Signature ……..
Dr. U.GAUTHAMADAS, M.D.,DPM.,Ph.D.,
PROFESSOR AND HEAD, DEPARTMENT OF PSYCHIATRY,
MAPIMS,
MELMARUVATHUR - 603 319.

A DISSERTATION SUBMITTED TO

THE TAMILNADU Dr. M.G.R. MEDICAL UNIVERSITY,

CHENNAI.

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

APRIL -2012

EFFECTIVENESS OF BEHAVIOUR CHANGE COMMUNICATION PROGRAMME ON AWARENESS OF HIGH RISK BEHAVIOUR AMONG ADOLESCENT BOYS IN SELECTED SCHOOL AT KANCHIPURAM DISTRICT

By

Mr. S.KARTHIK

M.Sc.,(Nursing) Degree examination,

Branch – V PsychiatricNursing,

Adhiparasakthi College Of Nursing,

Melmaruvathur – 603 319.

A Dissertation submitted to **THE TAMIL NADU Dr. M.G.R. MEDICAL UNIVERSITY, CHENNAI,** in partial fulfilment of the requirement for the Degree of **Master Of Science in Nursing, April-2012.**

_____ _____

INTERNAL EXAMINER **EXTERNAL EXAMINER**

ACKNOWLEDGEMENT

ACKNOWLEDGEMENT

My most heartfelt gratitude is articulated to **HIS HOLINESS ARUL THIRU AMMA**, **Founder,** Melmaruvathur, for his graceful blessings and guidance, which enabled me to reach up to this level and to complete my study.

With great respect and honour I express my heartfelt thanks to **THIRUMATHI LAKSHMI BANGARU ADIGALAR**, **Chief Executive Officer**, Adhiparasakthi College of Nursing, Melmaruvathur, for given me the opportunity to pursue my study in this prestigious institution.

I extend my thanks to our beloved **SAKTHI THIRUMATHI B.UMADEVI**, **M.Pharm.,Ph.D., Correspondent,** Adhiparasakti College of Nursing, Melmaruvathur for her valuable caring spirit and enduring support by giving all the facilities for pursuing my study.

I feel pleasure to extend my gratitude and sincere thanks to **Dr. N. KOKILAVANI, M.Sc.(N).,Ph.D., Principal and Head of the Department- Research,** Adhiparasakthi College of Nursing, Melmaruvathur, for her patience and excellent guidance, without whom this study would not have been moulded this shape. Her

rich professional experience and efficient guidance helped me to step cautiously in the right direction.

I wish to extend my sincere gratitude and thanks to **Dr. U.GAUTHAMADAS, M.D.,DPM.,Ph.D., Professor, Head of the Department of Psychiatry,** Melmaruvathur, Adhiparasakthi Institute of Medical Science and Research for his suggestions, encouragement and guidance throughout the study.

I wish to express my heartful and sincere thanks to **Prof. K.NEELADEVI, M.sc.(N)., Principal,** Shenbaga College of Nursing, Chennai, for her content validity, encouragement and support throughout the study.

I wish to express my deep sense of gratitude and sincere thanks to **Prof. B.SHEEBA, M.Sc.(N)., M.Phil., Head of the Department of Psychiatric Nursing,** Adhiparasakthi College of Nursing, Melmaruvathur, for her esteemed guidance, keen interest, sustained patience and continuous inspiration, which lead to the completion of the study.

I wish to express my heartfelt gratitude and sincere thanks to **Prof. B.VARALAKSHMI, M.Sc.(N)., M.Phil., Vice Principal,** Adhiparasakthi College of Nursing, Melmaruvathur, for her valuable

and tangible guidance which enlightened my path to complete the work systematically.

I acknowledge my sincere gratitude and heartfelt thanks to **Mrs. B.KUMARI KALYANI, M.Sc.(N)., Lecturer,** Adhiparasakthi College of Nursing, Melmaruvathur, for her guidance and valuable suggestions in my study.

I feel pleasure to extend my gratitude and sincere thanks to **Mr. K.GANESH., M.Sc.(N)., Lecturer,** Adhiparasakthi College of Nursing, Melmaruvathur, for his guidance and valuable suggestions in my study.

I feel pleasure to extend my gratitude and sincere thanks to **Mr. B.ASHOK, M.Sc.,M.Phil., Lecturer in Bio-Statistics,** Adhiparasakthi College of Nursing, Melmaruvathur, for his guidance and support in statistical analysis for this study.

I feel pleasure to extend my gratitude and sincere thanks to **Mr. A.SURIYANARAYANAN, M.A.,M.Phil., Lecturer in English,** Adhiparasakthi College of Nursing, Melmaruvathur, for his guidance in editing grammatical error and making me a great success to complete my study.

I wish to express my thanks to **Mr. A.CHANDRAN, Librarian** of Adhiparasakthi College of Nursing, Melmaruvathur for referring the books and journals for my dissertation.

I wish to express my thanks to all the **Teaching Staff** of Adhiparasakthi College of Nursing, Melmaruvathur, who encouraged me and provided support throughout my study.

I would like to thank all **Non-Teaching Staff** of Adhiparasakthi College of Nursing, Melmaruvathur, who encouraged me and provided the support throughout my study.

I wish to express my thanks to **The Tamil Nadu Dr. M.G.R Medical University**, **Chennai,** for granting permission to utilize the library to refer books and journals.

I am deeply obliged to **The Head Master,** Government Boys Higher Secondary School, for granting permission and extending full co-operation, help and support in carrying out the research project.

I express my gratitude to all the **Study participants** who enthusiastically participated in carryingout the research project. I appreciate their keen interest, patience and co-operation evinced for successful completion of the study.

Finally, I thank all of them who have directly and indirectly helped me in the completion of this study.

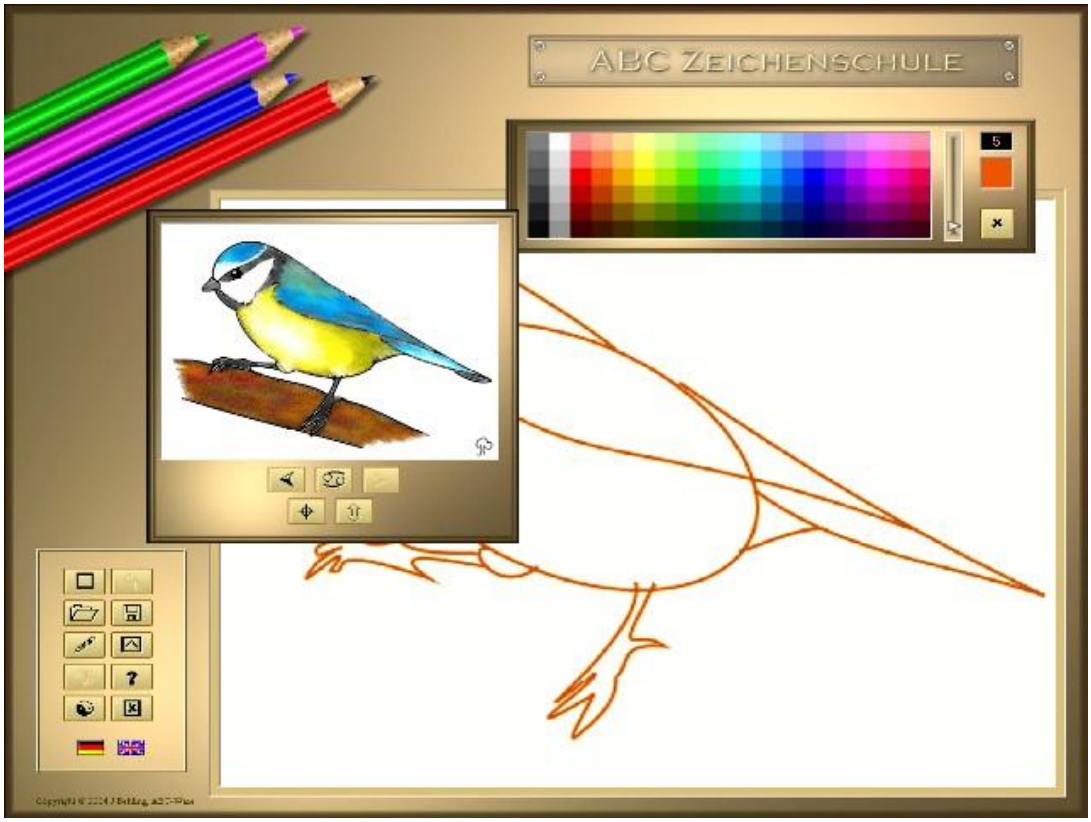
LIST OF CONTENTS

LIST OF CONTENTS

LIST OF TABLES

LIST OF TABLES

LIST OF FIGURES



LIST OF FIGURES

LIST OF APPENDICES

LIST OF APPENDICES

CHAPTER-I

INTRODUCTION

CHAPTER I

INTRODUCTION

Adolescence, the period of transition from childhood to adulthood, is a decade filled with profound and often confusing changes. Dramatic physical and psychological development is typically accompanied by cognitive, emotional and social changes, decreasing levels of adult's supervision; increasingly experimentation with adult behaviours and responsibilities; and changes in the milieu of school and work.

Youth risk-taking behaviour, such as drug use, engagement in violence, school dropout, and teenage pregnancy, known to have far-reaching implications on health, education, employment prospects, and income, which extend into adulthood. The relevance of the issue recently has led to a profusion of studies, including prevalence studies, clinical trials, and systematic reviews. All these studies give definitions of risk behaviour differently by many authors. Irwin (2004) defines high risk behaviour as all activities that will lead to a negative health outcome. Yates (2006) defined risk as multidimensional and

proposed a definition that includes the consideration of potential loss, probability of loss, and significance of the potential loss.

Various risk behaviours have been reported in the literature like substance abuse including tobacco smoking, alcohol consumption, illicit drug use, unprotected sexual intercourse, violent behaviour, negligence of traffic rules, suicide attempts and obesity.

In recent years substance use has increased greatly throughout the world. Adolescence is the critical period when the first initiation of substance use takes place. A community-based, cross-sectional study carried out among 260 randomly selected adolescents in an urban slum area in Hyderabad, India reported a prevalence of 37.2% between adolescents of 13-15 years.Another clinical series from Kerala indicated the overall prevalence of smoking among adolescent as 8%, and the awareness of subjects about ill effects of smoking was very poor, which indicated the need of standard intervention to improve the awareness and practice of such high risk behaviour.

Among various illicit substances, alcohol is one of the most widely used drugs in the world. Alcohol use, illicit drugs and binge drinking among our nation’s youth is a major public health

problem. Alcohol is an important factor in approximately 41% of all deaths from motor vehicle crashes. Among youth, the use of alcohol and other drugs have been linked to unintentional injuries, physical fights, academic and occupational problems, and illegal behaviour. In India the prevalence of alcohol in rural and urban community among adolescents had been found to be 7.37% and 5.23%. Next to alcohol use the trend of illicit drug use is slowly increasing among adolescents in our country, the prevalence ranges between 6.14% and 0.6% in rural and urban community.

Another distinctive area of issue is inappropriate sexual behaviour among adolescents. Despite restrictive social norms, there isanincreasing evidence that youth in India engage in premarital romantic and sexual partnerships. It was induced that several reasons including lack of well-defined policies stipulating how information should be provided and lack of appropriate HIV/AIDS information resources in school had been responsible for the inadequacy. It was concluded by many nations that pupils in secondary schools need to be informed about HIV/AIDS in order to influence their behaviour to avoid HIV infection.

Next substantial issue today in the modern world among youth is suicide. Global mortality data indicates suicide as the

fourth leading cause of death among young male and the third for young female. Official data from India demonstrates a 27.7% increase in recorded number of suicides between 1995 and 2005 with a current suicide rate of 10.5/1 000 000 about 35% of suicides occur amongst youth (15–29 years). Thus, suicide among young people has emerged as a major public health issue in India.

At last a psycho social and metabolic oriented disease which is slowly affecting adolescents of our country is obesity. Childhood obesity is increasingly being observed with the changing lifestyle of families with increased purchasing power, increasing hours of inactivity due to television, video games, and computers, which are replacing outdoor games and other social activities. The World Health Organization has described obesity as one of today's most neglected public health problems. Following the increase in adult obesity, the proportion of children and adolescents who are overweight and obese have also been increasing the magnitude of overweight ranges from 9% to 27.5% and obesity ranges from 1% to 12.9% among Indian children .

NEED FOR THE STUDY

High risk behaviours are established during childhood and adolescence and can extend into adulthood. Therefore,

encouraging the adoption of healthy behaviours during childhood is easier and more effective than trying to change unhealthy behaviours during adulthood. According to the YRBS (youth risk behaviour survey 2009), far too many youth are still engaging in health risk behaviours. As a matter of fact, the health risk behaviours adopted in youth contribute to the leading causes of death, disability, and social problems in adulthood, specifically tobacco use; unhealthy eating; inadequate physical activity; alcohol and other drug use; sexual behaviours that may result in HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancy; and behaviours that contribute to unintentional injury and violence. These behaviours are often established during childhood and persist into adulthood. However, they are largely preventable.

Therefore, school health programs should focus on reducing these health risk behaviour areas. Research has shown that school health programs can reduce the prevalence of health risk behaviours among young people and have a positive effect on academic performance. Scientific reviews have documented that school health programs can have positive impacts on educational

outcomes, as well as health-risk behaviours and health outcomes. , Hence, early intervention can improve long-term outcomes.

Another rationale for selecting this area for study is previous studies conducted about high risk behaviours were of observational studies which monitored the change in behaviour after the intervention. According to the investigator view, the above method alone will not change the risky behaviour. A very essential component to change in behaviour is perception of a situation, which is supported by a theoretical model risk perception theory. According to risk perception theory, Perception of risk influences the decisions with regard to risk taking. One theory of risk perception proposes that the perceived riskiness of an activity is influenced by a number of factors. These include whether the risk is voluntary or involuntary, whetherthe risks of the activity are known to the individual, and whether the risk is familiar or unfamiliar. Consistent with this theory, an investigation within a small sample of high school students across five risk behaviours found that adolescents who reported participation in risk behaviours also reported awareness of risks, less risk to self and others, less seriousness of effects, more control over the risks and higher involuntary nature of the risk activity. . Hence the basic

process is change in perception. Perception is directly related to the awareness level of an individual. An individual with adequate awareness about the situation alone can visualize a risky situation in a better way so as to safeguard himself from the deleterious effect out of it. Hence the investigator in the present study chose a Behavior change communication programme to impart awareness on high risk behaviour among adolescent, so as to change their perception of the risky event, which may help in better decision making. Another factor which propelled the investigator to conduct the present study is lack of Indian literature to document the effectiveness of Behaviour change communication in improving the awareness of high risk behaviour among adolescents.

STATEMENT OF THE PROBLEM

EFFECTIVENESS OF BEHAVIOUR CHANGE COMMUNICATION PROGRAMME ON AWARENESS OF HIGH RISK BEHAVIOUR AMONG ADOLESCENT BOYS IN SELECTED SCHOOL AT KANCHIPURAM DISTRICT

OBJECTIVES

- to assess the prevalence and awareness of high risk behaviour among adolescent boys**.**

- to assess the effectiveness of behaviour change communication program on awareness of high risk behaviour and its prevention among adolescent boys**.**
- to associate the effectiveness of behaviour change communication program with the selected demographic variables.
- to associate the risk behaviours and awareness among adolescent boys

OPERATIONAL DEFINITION

EFFECTIVENESS

It refers to the extent to which Behaviour change communication has achieved the desired result intended, measured in terms of significant increase in the post test score in terms of awareness attitude of the subject.

BEHAVIOUR CHANGE COMMUNICATION

This is a strategy, which refers to the systematic attempt to modify/influence behaviour, or practices and environmental factors related to high risk behaviours, which indirectly or directly promote health, preventillness or protect individuals from harm by means of

educating and discussing on the hazards of risk behaviours by using audio visual aids for 45 minutes among the students of 10^{th}, 11^{th} and 12^{th} standards.

AWARENESS

It refers to the understanding and the awareness of the subjects regarding high risk behaviour, their types, risk factors, effects and its prevention as measured by the awareness questionnaire and scored as adequate, moderately adequate and inadequate awareness.

HIGH RISK BEHAVIOURS

A task undertaking by an adolescent boy which involves a challenge for achievement or a desirable goal in which there is a lack of certainty or a fear of failure. It may also include the exhibiting of certain behaviours whose outcomes may present a risk to the individual or others. It includes alcohol abuse, drug abuse, smoking, violence, unprotected sex, obesity, suicide.

ADOLESCENT BOYS

Developmental period between childhood and adulthood, beginning with changes associated with puberty and culminating in the acquisition of adult roles and responsibility, usually between the age of 15 year to 19 year.

HYPOTHESIS

- H_1 – There will be a significant difference between the pre and posttest scores regarding awareness of high risk behaviour among adolescent boys.
- H_2 – There will be significant association between posttest awareness score with the selected risk behaviours.

DELIMITATIONS

- The study was limited to government boys higher secondary school Acharapakkam, Kanchipuram District.
- The study was limited to sample size 100.
- The period of study was limited to six weeks.
- The study was limited to 10^{th}, 11^{th}, 12^{th}standard students.
- The finding cannot be generalized.

CONCEPTUAL FRAMEWORK

Conceptual framework is a network of inter related changes that provide a structure for organizing and describing the phenomenon of interest. Research studies based on the theoretical or conceptual framework that facilitates visualizing the problem and places the variable in a logical context.

The framework in this study was based upon modified Wiedenbach (2007) nursing art theory with the concept of observation, ministering help, and validation. In Wiedenbach's nursing art, three steps are comparable with nursing process phases of assessment, implementation and evaluation.

According to Wiedenbach, nursing is based on goal directed care. It consists of three steps.

- Step 1- observation
- Step2 – ministering help
- Step 3 – validating the need for help was met.

Observation

The first phase of observation considers the person holistically and requires extensive data collection. Here the

investigator explores with adolescence experience of high risk behaviours. It includes the following components,

- **General information**

  This comprises of the inclusion and exclusion criteria proposed for the selection of sample and demographic variable.

- **Central purpose**

  Central purpose is to increase the awareness of high risk behaviours among adolescent boys.

- **Prescription**

  It includes the intervention prescribed to meet the central purpose (behaviour change communication programme)

In this study observation is assessing various demographic variables and high risk behaviour questions like age, sex, educational status, type of family, part time job, family member habits, academic performance, driving vehicle, smoking, tobacco chewing, alcohol, acting out behaviour, suicide, unprotected sex and obesity.

Ministering help

Here the investigator formulates and implement the plan. This include a component called reality which includes four components,

- **Agent**

  The investigator act as an agent to render the needed help.

- **Recipient**

  The adolescent boys with high risk behaviour.

- **Goal**

  The goal is to improve the awareness of high risk behaviour among adolescent boys through the Behaviour change communication programme.

- **Facilities**

  It denotes the setting where the help is rendered. (selected boys higher secondary school at Kanchipuram District).

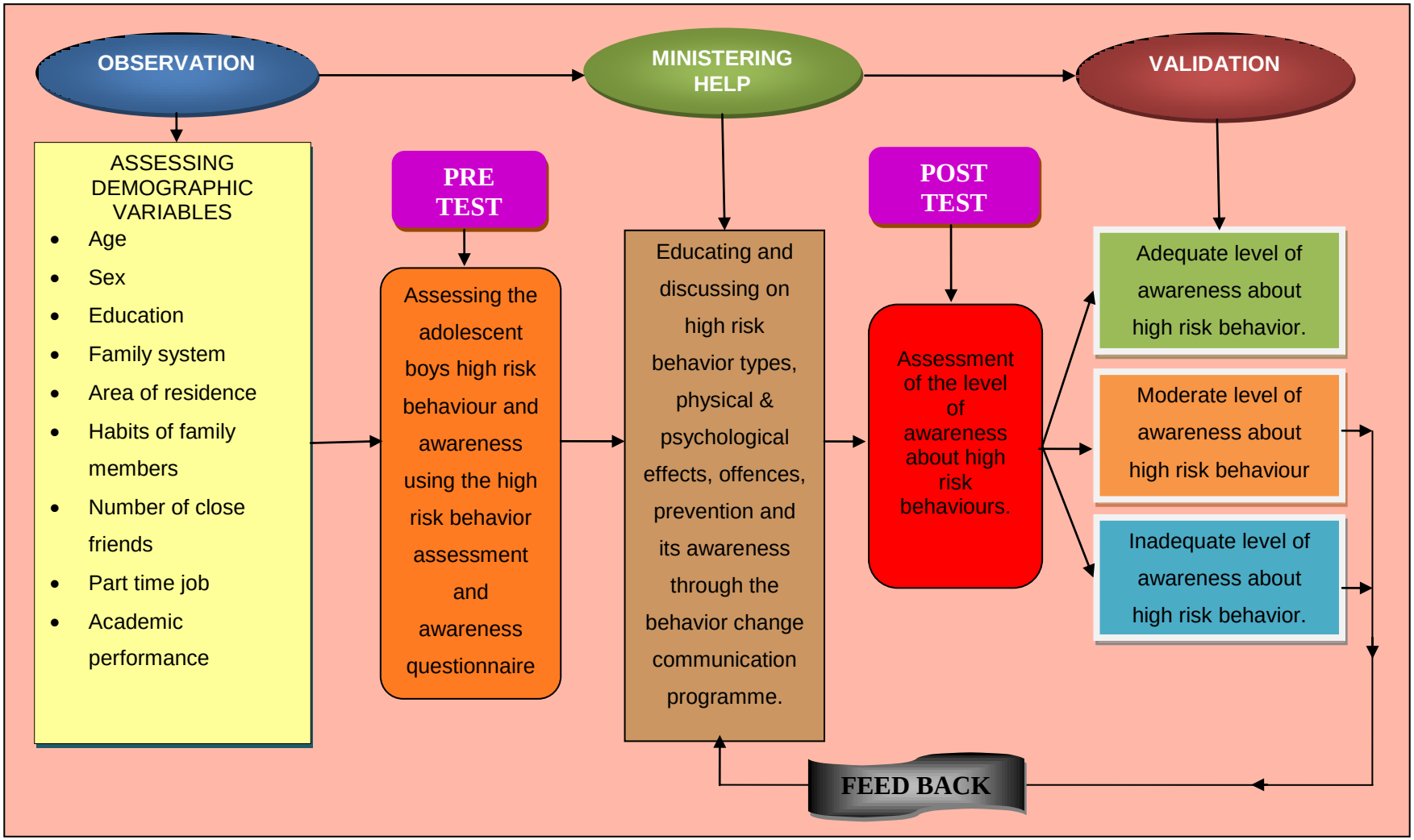
  In this study administering Behaviour change communication programme for a period of thirty minutes to fourty five minutes.

Validation

It validates the needed help that delivered in achieving the central purpose. In this study indicates the effectiveness of Behaviour change communication programme and it is measured in terms of grading as adequate, moderately adequate and inadequate level of awareness about high risk behaviours.

Feedback

For those who have moderately inadequate and inadequate level of awareness about high risk behaviours to provide Behaviour change communication programme.



CONCEPTUAL MODEL BASED ON MODIFIED WIEDENBACH THEORY (2011)

CHAPTER-II

REVIEW OF LITERATURE

CHAPTER II

REVIEW OF LITERATURE

Review of literature is an essential step in the development of a research project. It involves the systematic identification, location, scrutiny and summary of written materials that contain information on research problems. The investigator reviewed the related literature to broaden the understanding and gain insight in to the selected problem under study.

A good research does not exist in the vacuum. Research findings should be an extension of previous awareness and the theory as well as a guide for future research activities. A thorough study of literature provides a foundation to base new awareness.

A review of literature provides the concept to continue or written for the contemplated research, an understanding the status of research in the problem area and clues research approach, method instrumentation and analysis. The literature review was organized under the following headings.

I. **LITERATURE REVIEW ON PREVALENCE OF HIGH RISK BEHAVIOUR AMONG ADOLESCENTS.**

II. **LITERATURE REVIEW ON INTERVENTION FOR HIGH RISK BEHAVIOUR OF ADOLESCENTS.**

I. LITERATURE REVIEW ON PREVALENCE OF HIGH RISK BEHAVIOUR AMONG ADOLESCENTS.

Slopen N, Fitzmaurice GM., (2011) conducted a study to assess the pattern of violence behaviour among adolescents in rural and urban community. The sample included 2,345 adolescents from a community-based sample in the US. The study documented a high risk for developing anxiety and depression among adolescents subjected to family violence. The study recommended prevention and treatment efforts should target adolescents exposed to violence in multiple settings.

Baheiraei A, Hamzehgardeshi Z., (2011) conducted a population-based cross-sectional study, to determine the prevalence of intentional injuries and associated factors among 1201 adolescentsin Tehran, Iran. Overall, 63.9% of adolescents had at least one intentional injury behaviour which was significantly higher in males. Gender preference for males by

parents, very high or very low supervision, waterpipe smoking, and alcohol consumption were significantly associated with injuries in females. In addition, poor wealth index, parental punishment and smoking were incriminating factors in males.

Ghosh A., (2011) conducted a study to assess the prevalence of obesity among children and adolescents. A total of 753 healthy children and adolescents, out of which 293 (159 boys and 134 girls) were collected Santiniketan (rural area) and 460 (241 boys and 219 girls) were from Calcutta and the suburbs (urban area); aged 8 to 18 years took part in the study. It was observed that the overall prevalence of overweight and obesity in the study was 9.6% and 5.7%, respectively. Urban residence and high level of parental education are associated with overweight and obesity in children and adolescents 40.3%.

Hepp U, Stulz N., (2011) conducted a study to document the prevalence and pattern of adolescents suicidal behaviour. Of the 12,226 suicides which took place in this 10-year period, 333 were committed by children and adolescents (226 males, 107 females). The most prevalent methods of suicide in children and adolescents 0-19 years were hanging, jumping from heights and railway-suicides (both genders), intoxication (females) and

firearms (males). Compared to adults, railway-suicides were over-represented in young male and female. Jumping from heights was over-represented in young males. Thus, availability has an important effect on methods of suicide chosen by children and adolescents. The study documented restricting access to most favoured methods of suicide might be an important strategy in suicide prevention.

Misra A, Shah P, et al., (2011) conducted a study to assess the prevalence of obesity in school going children in 5 cities of India. A total of 38,296 children participated in this study the prevalence of overweight and obesity in 8- to 18-year-old children, respectively, was 14.4 and 2.8% by IOTF cut offs, 14.5 and 4.8% by CDC cut offs and 18.5 and 5.3% by WHO cut offs. When applying the cutoffs specific for Indian ethnicity in 14- to 18-year-old children, the prevalence was higher (21.1 and 12.3%, respectively) as compared to the IOTF, WHO and CDC cutoffs. The overall prevalence of abdominal obesity in urban Indian schoolchildren was 4.5%. The prevalence of overweight and abdominal obesity was significantly higher in females than males.

Mudingayi A, Lutala P, Mupenda B., (2011) conducted a study to assess the level of awareness about sexually transmitted

infections (STIs), including HIV, among street adolescents in the Democratic Republic of the Congo (DRC). 200 street children (10-25 years of age) were included in the study. The results revealed the awareness level of respondents was high. 54.3% of males and 45.7% of girls have heard about HIV), and few participants cited unprotected sex as mode of transmission (42.9% for males and 57.1% for females). A high number of children reported a previous sexual experience. Satisfying a natural bodily need was the main reason for having sex. However, the use of condoms is still low in both genders (26.2 versus 59.3%, $p<0.01$). Neither gender reported a reason why they are not using a condom.

Peltzer K., (2011) conducted a study to assess the prevalence and common correlates of early smoking initiation among male and female school children across seven African countries. The total sample included 17,725 school children aged 13 to 15 years from nationally representative samples in seven African countries. Overall 15.5% had experienced smoking initiation before age 14, with the percentages 20.1% among boys and 10.9% among girls. In multivariable analysis, early smoking initiation was among boys associated with ever drunk from alcohol use, ever used drugs and ever had sex.

Among girls, it was associated with higher education, ever drunk from alcohol use, parental or guardian tobacco use and suicide ideation. Specific interventions are needed for boys and girls in the preteen years, before smoking initiation.

Tsering D, Pal R, Dasgupta A., (2010) conducted a study to assess the magnitude of licit and illicit substance use among students of eastern India. 416 high school students from two schools of west Bengal participated in this study. The overall prevalence rates among rural and urban students were 6.14% and 0.6% for illicit drug use, 8.60% and 11.04% for tobacco, and 7.37% and 5.23% for alcohol consumption, respectively. Both licit and illicit substance use was associated more with male students. Current and regular uses were mostly restricted to tobacco, and the use of a substance by family members had a significant impact on its use by their children. "Enjoyment" and "Curiosity" were found to have the major influence in their decision to use a substance.

Maswanya ES, Moji K., (1999) conducted a questionnaire survey to find out relationship between HIV-risky sexual behaviour and anti-condom bias, as well as with AIDS-related information, awareness, perceptions and attitudes among 1041 adolescents. Self-reportedly, 54% of students (75% of the boys

and 40% of the girls) were sexually active, 39% had a regular sexual partner and 13% had multiple partners in the previous year. The condom use rate was higher than previous reports. However, 30% of sexually active respondents did not always use condoms and 35% of those with multiple partners in the previous year did not always use condoms.

II. LITERATURE REVIEW ON INTERVENTION FOR RISK BEHAVIOURS OF ADOLESCENTS.

a) Literature related to alcohol abuse

Donovan E, Wood M, Frayjo K, Black RA, Surette DA., (2011) conducted a study using a booklet that contains information about alcohol abuse among School going children of USA. The study included 558 participants assigned either in to intervention group and control group. The study results indicated that Students who received the intervention were more likely to use a range of protective behavioural strategies, particularly those related to manner of drinking and stopping/limiting drinking, as compared with students who did not receive the intervention

Huiberts A, Boon B, Risselada A, Riper H, Smit F., (2011) conducted a study comprising interventions that deliver online personalized feedback on alcohol use. The study included 450

participants who were either divided into control and experimental group. The study revealed that 42% participants were successful in reducing their drinking levels to below the threshold at the 1-month follow-up.

Lammers J, Goossens F, Lokman S, Monshouwer K, Lemmers L, Conrod P, Wiers R, Engels R, Kleinjan M., (2011) developed a protocol to test the effectiveness of selective prevention programme to prevent adolescents from binge drinking. The study design was randomized controlled trial conducted among 13 to 15-year-old adolescents in secondary schools. The intervention condition consisted of two 90 minute group sessions, carried out at the participants' schools and provided by a qualified counselor and a co-facilitator. The control condition received no further intervention above the standard substance use education sessions provided in the Dutch national curriculum. This intervention programme emphasizes the importance of school health education in reducing alcohol use behaviour among adolescent.

Caria MP, Faggiano F, Bellocco R, Galanti MR; EU-Dap Study Group., (2011) conducted a national wide school based prevention programme against substance use on the frequency of

alcohol consumption and alcohol-related problem behaviours among European students. A total of 7,079 students aged 12-14 years from 143 schools participated.Schools were randomly assigned to either control (65 schools, 3,532 students) or to a 12-session standardized program. Alcohol use and frequency of alcohol-related problem behaviours were investigated through a self-completed anonymous questionnaire at baseline and 18 months thereafter. The preventive program was associated with a decreased risk of reporting alcohol-related problems.

b) Literature related to drug abuse

Berridge BJ, Hall K, Dillon P, Hides L, Lubman DI., (2011) conducted a Making the link programme pilot study with 10 students at a secondary school in Melbourne, Australia. Forty teachers received the Making the link staff professional development session. The results indicated the delivery of the making the link programme was found to be both acceptable and feasible within a school setting. Students reported increased confidence and awareness of how to seek help for them-selves or a friend, and teachers indicated increased confidence and awareness of how to assist students to seek help for cannabis use and/or mental health problems.

Kilmer B, Burgdorf JR, D'Amico EJ, Miles J, Tucker J., (2011) conducted a study to assess the effectiveness of school-based voluntary alcohol and drug prevention program in USA. The intervention consists of Project choice, a voluntary after-school alcohol and other drug prevention program for adolescents. The results indicated a significant reduction in alcohol and drug agues behaviour among adolescents. The authors have also concluded the intervention as the cost effective programme for adolescents.

EU-Dap Study Group., (2010) conducted a study to evaluate the effectiveness of a school-based substance abuse prevention program developed in the EU-Dap study (European Drug Addiction Prevention trial). 170 schools (7079 pupils 12-14 years of age) were randomly assigned to one of three experimental conditions or to a control condition. The program consisted of a 12-h curriculum based on a comprehensive social influence approach. Persisting beneficial program effects were found for episodes of drunkenness and for frequent cannabis use in the past 15days; whereas daily cigarette smoking was not affected by the program as it was at the short-term follow-up. Baseline non-smokers that participated in the program progressed in tobacco consumption to a lower extent than those in the control

condition, but no difference was detected in the proportion of quitters or reducers among baseline daily smokers.

c) Literature related to smoking

Sohn M, Ahn Y, Park H, Lee M., (2011) conducted a study to test the effectiveness of Simulation-based smoking cessation intervention education for undergraduate nursing students. The study was a one-group, quasi-experimental study was conducted to describe a simulation-based training of smoking cessation intervention and to evaluate its effectiveness on nursing students' self-efficacy in performing smoking cessation intervention. The simulation-based training of smoking cessation intervention improved nursing students' self-efficacy in seven out of nine skills of smokingcessation intervention.

Thomas RE, Baker P, Lorenzetti D., (2007) conducted a systematic review about Family-based programmes for preventing smoking by children and adolescents. 19 RCTs of family interventions to prevent smoking was included in that review. In this review demonstrated family intervention programme was effective in reducing high risk smoking behaviour.

Thomas R., (2002) conducted a systematic review through Cochrane about School-based programmes for preventing

smoking. The systematic review included 76 trials in total. The pooled analysis of the previous data set revealed limited evidence about the effectiveness of multi-modal approaches including community initiatives .They also suggested a need for well controlled intervention programme.

d) Literature related to violence

Crooks CV, Scott K, Ellis W, Wolfe DA., (2011) to assess the impact of a universal school-based violence prevention program on violent delinquency, distinctive benefits for youth with maltreatment histories. Students from 20 schools participated in 75-min lessons in grade 9 health classes. The study found a positive outcome in terms of reduction in violent behaviour among school going students.

Howard J, Friend D, Parker T, Streker G., (2010) conducted a study with the help of SMS to support parents who experience violence from their adolescents. The project involved 19 consumers (through focus groups) to design the SMS messages that would most benefit them, decide how often and when they would be sent and evaluate their usefulness in supporting them to take a stand against their adolescent's abuse and violence in the home. The project findings demonstrated that

SMS messages were useful and supported parents to make changes and address their adolescent's abuse and violence.

e) Literature related to sexual behaviour

Nair MK, Paul MK, Leena ML, Thankachi Y, George B, Russell PS, Pillai H., (2011) conducted a study to test the Effectiveness of a Reproductive Sexual Health Education Package among School Going Adolescents. The study sample consisted of 1,586 adolescents including 996 boys and 560 girls of class IX and XI. In the pre-intervention period, it was observed that majority of adolescents were poorly informed about reproductive sexual health matters, particularly about contraceptives. As compared to boys, girls had much poorer awareness about prevention of pregnancy and after intervention; there was a statistically significant increase in the awareness in both boys and girls. Among girls percentage of poor awareness had reduced significantly from 64.1% to 8.3% and among boys from 37.7% to 3.5%. Similarly, increase in awareness level was also observed in various other aspects of reproductive and sexual health including, STI, HIV/AIDS and perceptions about premarital sex.

Rijsdijk LE, Bos AE, Ruiter RA, Leerlooijer JN, de Haas B, Schaalma HP., (2011) conducted a study to evaluates the

effect of the World Starts With Me (WSWM), a comprehensive sex education programme in secondary schools in Uganda. A survey was conducted both before and immediately after the intervention among students in intervention and comparison groups. Significant positive effects of WSMW were found on beliefs regarding what could or could not prevent pregnancy, the perceived social norm towards delaying sexual intercourse, and the intention to delay sexual intercourse. Furthermore, significant positive effects of WSWM were found on attitudes, self-efficacy and intention towards condom use and on self-efficacy in dealing with sexual violence (pressure and force for unwanted sex). A reversed effect of intervention was found on awareness scores relating to non-causes of HIV (petting, fondling and deep kissing).

Kirby D, Obasi A, Laris BA., (2006) conducted a study to assess the effectiveness of sex education and HIV education interventions in schools in developing countries.This study was a systematic that included Twenty-two intervention, 17 were based on a curriculum and 5 were not, and 19 were implemented primarily by adults and 3 by peers. These 22 interventions significantly improved 21 out of 55 sexual behaviours measured. Only one of the interventions (a non-curriculum-based peer-led

intervention) increased any measure of reported sexual intercourse; 7 interventions delayed the reported onset of sex; 3 reduced the reported number of sexual partners; and 1 reduced the reported frequency of sexual activity.

Fawole IO, Asuzu MC, Oduntan SO, Brieger WR., (2009) conducted a school-based AIDS education programme for secondary school students in Nigeria. In this study, the awareness, attitude and sexual risk behaviours of 223 students who received a comprehensive health education intervention were compared with 217 controls. At post-test, intervention students exhibited greater awareness about HIV/AIDS transmission and prevention. Among the intervention students there was also an increase in consistent use of the condom and the use of the condom at last sexual intercourse. We conclude that students can benefit from specific education programmes that transmit important information necessary to prevent risky behaviour, and improve awareness and attitudes on HIV/AIDS.

Klepp KI, Ndeki SS, Leshabari MT, Hannan PJ, Lyimo BA., (2007) conducted a study was to test the effects of an education program in Tanzania designed to reduce children's risk of human immunodeficiency virus (HIV) infection and to improve

their tolerance of and care for people with acquired immunodeficiency syndrome (AIDS) Results indicated Statistically significant effects favoring the intervention group were observed for exposure to AIDS information and communication, AIDS awareness, attitudes toward people with AIDS, and subjective norms and behavioural intentions toward having sexual intercourse. A consistent positive but non-significant trend was seen for attitudes toward having sexual intercourse and for initiation of sexual intercourse during the previous year.

Aplasca MR, Siegel D, Mandel JS, Santana-Arciaga RT, Paul J, Hudes ES, Monzon OT, Hearst N., (1995) conducted a study to describe the sexual practices of high school students; to describe the process of development of a school-based AIDS prevention program; and to evaluate the effect of this program on students' AIDS-related awareness, attitudes and AIDS-preventive behaviours. Study results indicated after implementation of the AIDS prevention program, statistically significant effects favoring the intervention group were observed in awareness and attitudes towards people with AIDS.

f) Literature related to suicide

Cusimano MD, Sameem M., (2011) did a systematic review of the effectiveness of middle and high school-based suicide prevention programmes for adolescents. Overall, statistically significant improvements were noted in awareness, attitude, and help-seeking behaviour. A decrease in self-reported ideation was reported in two studies. None reported on suicide rates. The authors also recommended Further well designed, controlled research is required before such programmes are instituted broadly to populations at risk.

King KA, Strunk CM, Sorter MT., (2011) conducted a study which examined the immediate and 3-month effect of Surviving the Teens Suicide Prevention and Depression Awareness Program on students' suicidality and perceived self-efficacy in performing help-seeking behaviours. A total of 1015 students participated in the program. Students were significantly less likely at 3-month follow-up than at pretest to be currently considering suicide, to have made a suicidal plan or attempted suicide during the past 3 months, and to have stopped performing usual activities due to feeling sad and hopeless. Students' self-efficacy and behavioural intentions toward help-seeking

behaviours increased from pretest to posttest and were maintained at 3-month follow-up. Students were also more likely at 3-month follow-up than at pretest to know an adult in school with whom they felt comfortable discussing their problems. Nine in 10 (87.3%) felt the program should be offered to all high school students.

Aseltine RH Jr, De Martino R., (2004) examined the effectiveness of the Signs of Suicide (SOS) prevention program in reducing suicidal behaviour among school going adolescents. Twenty-one hundred students in 5 high schools in Columbus and Hartford, Conn, were randomly assigned to intervention and control groups. Significantly lower rates of suicide attempts and greater awareness and more adaptive attitudes about depression and suicide were observed among students in the intervention group. The modest changes in awareness and attitudes partially explained the beneficial effects of the program.

g) Literature related to obesity

Flattum C, Friend S, Story M, Neumark-Sztainer D., (2011) conducted an individualized counseling approach as part of a multicomponent school-based program to prevent weight-related problems among adolescents. During the individual sessions, which incorporated motivational interviewing strategies,

adolescents set targeted behavioural goals aimed at preventing a spectrum of weight-related problems. The results indicated positive behaviour among adolescents who underwent this intervention.

Siega-Riz AM, El Ghormli L, Mobley C, Gillis B, Stadler D, Hartstein J, Volpe SL, Virus A, Bridgman J; HEALTHY Study Group., (2011) conducted a multicenter healthy project to respond to the alarming trends in increasing rates of overweight, obesity, and type 2 diabetes mellitus in youth.The reported average daily fruit consumption was 10% higher at the end of the study in the intervention schools than in the control schools. The reported water intake was approximately 2 fluid ounces higher in the intervention schools than in the control. There were no significant differences between intervention and control for mean intakes of energy, macronutrients, fiber, grains, vegetables, legumes, sweets, sweetened beverages, and higher- or lower-fat milk consumption.

CHAPTER-III

METHODOLOGY

CHAPTER III

METHODOLOGY

This chapter deals with the methodology adopted for the study includes the description of research design, population, and sample size, sampling technique, criteria for sample selection, data collection and instruments.

RESEARCH DESIGN

A one group pretest and posttest quasi experimental design had been used to evaluate the effectiveness of behaviour change communication programme on awareness of high risk behaviours among adolescent boys.

SETTING

Research setting refers to the physical location and condition in which data collection taken place in the study. The research was conducted in government boys' higher secondary school at Acharapakkam, Kanchipuram district. The total strength of the school was 1148; the total number of 10^{th}, 11^{th}, 12^{th} students was 604.

POPULATION

The population of the study comprised of all adolescent boys between 15 to 19 years of age studying 10^{th}, 11^{th}, 12^{th} standard who met the inclusion criteria.

SAMPLE SIZE

The size was 100 adolescent boys in the age group between 15 to 19 years, who met the inclusion criteria, had been selected.

SAMPLING TECNIQUE

Probability sampling technique by using stratified random sampling method was adopted to select the samples.

CRITERIA FOR SAMPLE SELECTION

Inclusion criteria

- The study includes only male students in the age group of 15 to 19 years.
- A boys who could comprehend Tamil / English.
- Those who are studying 10^{th}, 11^{th}, and 12^{th}.

Exclusion criteria

- Samples included in the pilot study.
- Samples who were not willing to participate in study.

INSTRUMENTS FOR DATA COLLECTION

The scholar constructed the Instrument based on the objectives of the study through literature review and expert's guidance .The data collection is derived the following headings.

SECTION I - DEMOGRAPHIC PROFORMA

This section consists of information about demographic variables such as age of adolescents, standard, religion, family income, number of close friends, type of family, part time job, living with parents; receive pocket money, habits of family members, obesity in family members, academic performance.

SECTION II – QUESTIONNAIRE ON ASSESSMENT OF HIGH RISK BEHAVIOUR

This section consists of information about high risk behaviour assessment such as drive vehicle, carrying any harmful materials, felt unsafe, idea of running away, feeling sad, attempt suicide, smoking, chewing tobacco, consuming alcohol, personal appearance, sensitive, sexual intercourse, body weight etc.,

SECTION III – AWARENESS QUESTIONNAIRE ON HIGH RISK BEHAVIOUR

This section deals with questionnaire for assessment of level awareness regarding high risk behaviours. It consists of 30 multiple choice questions related to awareness regarding high risk behaviour among adolescents. Each correct answer had been given the score of one and the wrong answer had been given the score of zero. The total possible score was 30.

METHOD OF DATA COLLECTOIN

The study was conducted in government boys' higher secondary school at Acharapakkam, Kanchipuram district. The data was collected for a period of six weeks by using the prepared tools. The tools were developed based on the study objectives and through extensive review of literature.

CHAPTER-IV

DATA ANALYSIS AND INTERPRETATION

CHAPTER-IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with description of the tool, report of the pilot study, reliability, informed consent, data collection, score interpretation, data analysis and statistical method used in this study.

DESCRIPTION OF THE TOOL AND SCORING

The instrument used for the study consists of three sections they are

SECTION A: Demographic Proforma.

SECTION B: Questionnaire on assessment of high risk behaviour.

SECTION C: Questionnaire on awareness of high risk behaviour.

SECTION A

The demographic data consists of age, sex, class, religion, education, type of family, monthly family income, residence, family member's habits, number of close friends, residence, academic performance etc.

SECTION B

Assesssment of high risk behaviour questionnaire consists of high risk behaviours such as driving vehicle, consuming alcohol, smoking and tobacco chewing, obesity, unprotected sex and violence etc.,

SECTION C

Awareness regarding high risk behaviour was assessed through well prepared multiple choice questionnaire. It consists of 30 questions with the maximum score of 30. Each correct response was given a score of one and the wrong answer was given the score of zero.

VALIDITY

The tool was developed by the investigator under the guidance of the experts and based on extensive review of literature. Content validity was obtained from experts in the field of psychiatric nursing.

REPORT OF THE PILOT STUDY

Pilot study was conducted at government higher secondary School in Acharapakkam, kanchipuram district, for a period of seven days to ascertain the feasibility of data collection plan,

reliability of the tool and workability of data analysis. Prior permission was obtained from concerned authorities before the pilot study, 10 subjects from the school participated in the pilot study, who were excluded in the main study. Initially Awareness questionnaire was administered to assess the baseline knowledge about high risk behaviour and its prevalence among the adolescent boys. Following to pretest Behaviour change communication was given on adolescents and again at last posttest awareness was assessed by administering the same questionnaire. The data was analyzed by using paired‘t’ test; the calculated value was more than tabulated value. So effectiveness of behaviour change communication in enhancing the awareness on high risk behaviours among adolescent boys was found to be significant.

RELIABILITY

Reliability of the tool was tested by using test retest method. 10 subjects were chosen and administered the tool in two time with an interval of 10 days and the reliability co efficient was found to be reliable with r =0.80.

INFORMED CONSENT

The dissertation committee prior to the pilot study approved the research proposal. Permission was obtained from the concerned authorities. The oral consent from each adolescent boy was obtained before starting the data collection. Assurance was given to adolescent boys that confidentiality would be maintained.

DATA COLLECTION PROCEDURE

The adolescent boys had been screened initially according to inclusion and exclusion criteria and later they had been selected by stratified sampling technique. 100 adolescent boys had been selected from three strata i.e. 10^{th}, 11^{th}, 12^{th} students and their demographic data and prevalence of high risk behaviour was assessed using the pretested questionnaire. Later to find out the effectiveness of the behaviour change communication the data was collected in 3 phases. First phase, was the initial interview phase which was started on the first day and pretest was conducted using awareness questionnaire. In Second phase, behaviour change communication (education and group discussion) was given on various aspects of high risk behaviour. In the third phase post test was conducted using the same awareness questionnaire which was used for pretest. The time

taken for data collection approximately took about 45 minutes for each phase.

SCORE INTERPRETATION

The obtained data were interpreted by the following procedure.

$$\text{Score interpretation} = \frac{\text{Obtained score}}{\text{Maximum score}} \times 100$$

The scoring for the questionnaire on awareness of high risk behaviour:

S.NO	LEVEL OF AWARENESS	SCORE
1.	Adequate	> 75%
2.	Moderately adequate	50%-75
3.	Inadequate	< 50%

DATA ANALYSIS

Both descriptive and inferential statistical analysis method was to interpret the data in this study. Details were given below

Table: 4.1

S.NO	DATA ANALYSIS	METHODS	REMARKS
1.	Descriptive statistics.	Frequency, percentage, mean, standard deviation.	To describe the demographic variables. To describe the pretest and posttest awareness on high risk behaviour.
2.	Inferential statistics	Paired‘t’ test.	To analyze the effectiveness of behaviour change communication programme on awareness about high risk behaviours among adolescent boys.
		Chi- square test.	To analyze the association between the selected demographic variables with the awareness about high risk behaviour.

The analysis of data was organized and presented based on objectives in the following sections

Section A: Frequency and percentage distribution of demographic variables of the adolescent boys.

Section B: Frequency and percentage distribution of assessment of high risk behaviour among adolescent boys.

Section C: Comparison between the pretest and posttest level of awareness about high risk behaviour among adolescent boys.

Section D: Comparison between the mean and Standard deviation of pretest and posttest score about awareness of high risk behaviour.

Section E: Association of level of awareness about high risk behaviour with the selected demographic variables.

Section F: Association of level of awareness with the high risk behaviour.

SECTION A: FREQUENCY AND PERCENTAGE DISTRIBUTION OF DEMOGRAPHIC VARIABLES OF THE ADOLESCENT BOYS.

N=100

S.No	Demographic variables	Frequency	Percentage
1.	**Age**		
	a) 14 years	0	0
	b) 15 years	30	30
	c) 16 years	30	30
	d) 17 years and above	40	40
2.	**Class**		
	a) Tenth standard	30	30
	b) Eleventh standard	30	30
	c) Twelfth standard	40	40
3.	**Religion**		
	a) Hindu	72	72
	b) Christian	18	18
	c) Muslim	10	10
	d) Others	0	0
4.	**Family income**		
	a) Up to Rs.5000	65	65
	b) Rs.5001-Rs.10000	25	25
	c) Rs.10001-20000	6	6
	d) Above Rs.20000	4	4

5.	**Residence**		
	a) Rural	87	87
	b) Urban	13	13
6.	**Number of close friends**		
	a) One	22	22
	b) Two	43	43
	c) Three	21	21
	d) Four	14	14
7.	**Type of family**		
	a) Joint family	38	38
	b) Nuclear family	62	62
8.	**Part time job**		
	a) Yes	0	0
	b) No	100	100
9.	**Living with**		
	a) Parents	87	87
	b) Guardian	13	13
10.	**Pocket money**		
	a) Yes	62	62
	b) No	38	38
11.	**Use of tobacco in family**		
	a)Yes	34	34
	b)No	66	66

12.	**Use of alcohol in family**		
	a) Yes	52	52
	b) No	48	48
13.	**Use of illicit drugs in family**		
	a) Yes	0	0
	b) No	100	100
14.	**Obese person in the family**		
	a) Yes	18	18
	b) No	82	82
15.	**Academic performance**		
	a) Good	48	48
	b) Fair	32	32
	c) Poor	20	20

From table 4.2: shows the distribution of respondents according to certain demographic factors like age, class, religion, income, residence, number of friends, etc.,

Among 100 adolescents, 30 (30%) were in the age group of 15 years, 30 (30%) in the age group of 16 years and 40 (40%) in the age group of 17 years and above.

Regarding the class, 30 (30%) studying in tenth standard, 30 (30%) in eleventh standard and 40 (40%) in twelfth standard.

The religion of the adolescents reveals that 72 (72%) were Hindu, 10 (10%) Muslim and 18 (18%) Christian.

The residence of the subjects revealed that 87 (87%) were in rural and 13 (13%) in urban.

Among the respondents, 43 (43%) reported have two friend, 14 (14%) reported having four close friends.

With regards to family type, 38 (38%) were living in joint family, 62 (62%) in nuclear family.

With regard to part time job all the subjects 100 (100%) reported that they don’t have any part time job

Regarding with whom they live, 87 (87%) with parents, 13 (13%) with guardian.

With respect to receiving pocket money 62 (62%) said that they are receiving and rest 38 (38%) said that they are not receiving any pocket money from their caregivers.

Regarding the tobacco usage in family, 34 (34%) reported tobacco usage in family whereas 66 (66%) reported not using any tobacco among their family members.

In the case of use of alcohol in their family, 52 (52%) reported alcohol usage in family whereas, 48 (48%) reported not using any alcohol among their family members.

When asking about the use of illicit drugs in the family, out of 100 (100%) stated that they have not using any illicit substance among their family members.

With relation to self-perception of obese18 (18%) perceived themselves as obese whereas the rest 82 (82%) perceived themselves as normal weight.

Regarding the academic performance, 48 (48%) reported performing good and 20 (20%) performing poor.

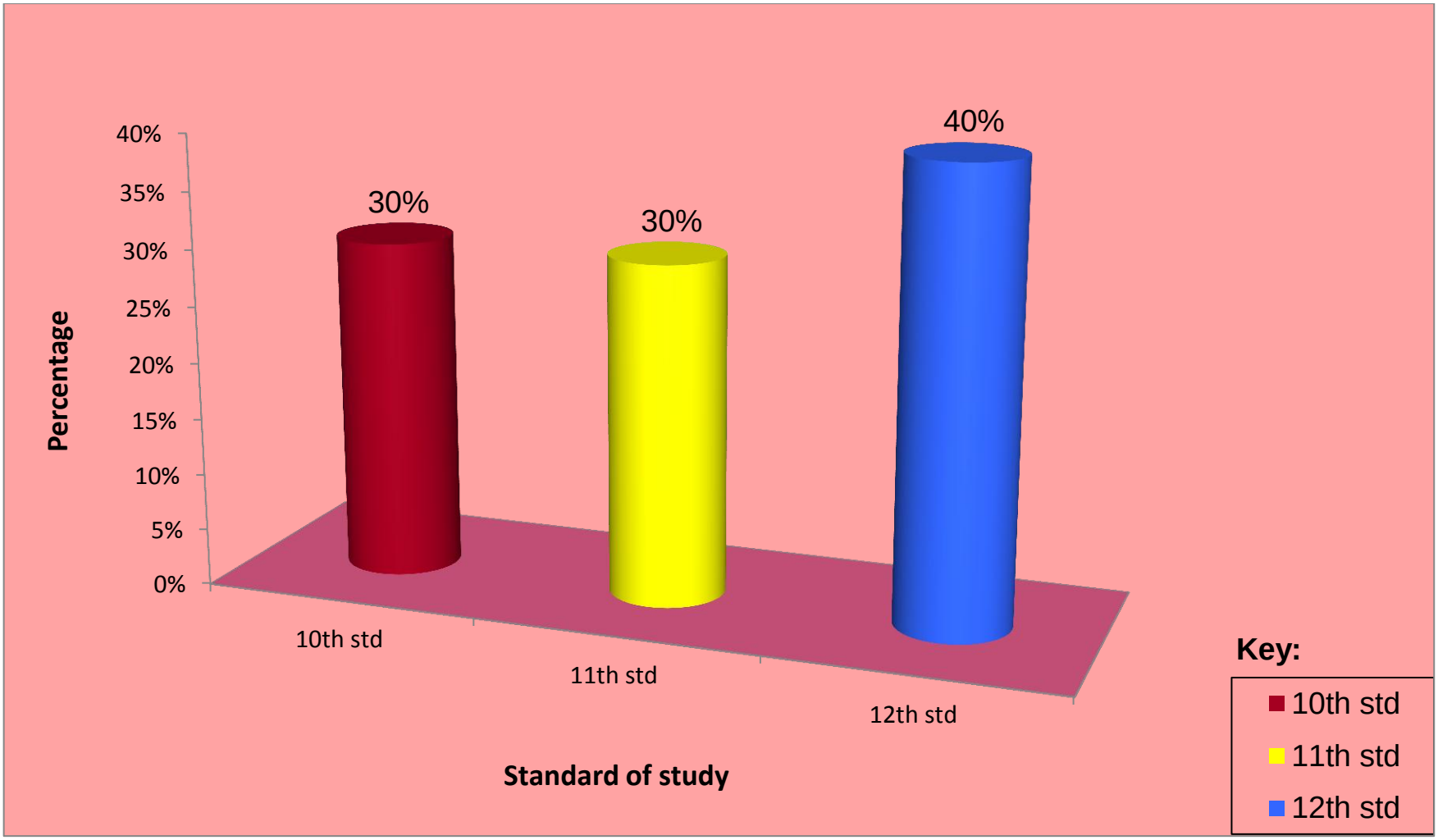


FIG 4.1: PERCENTAGE DISTRIBUTION OF ADOLESCENT BOYS BASED ON STANDARD OF STUDY

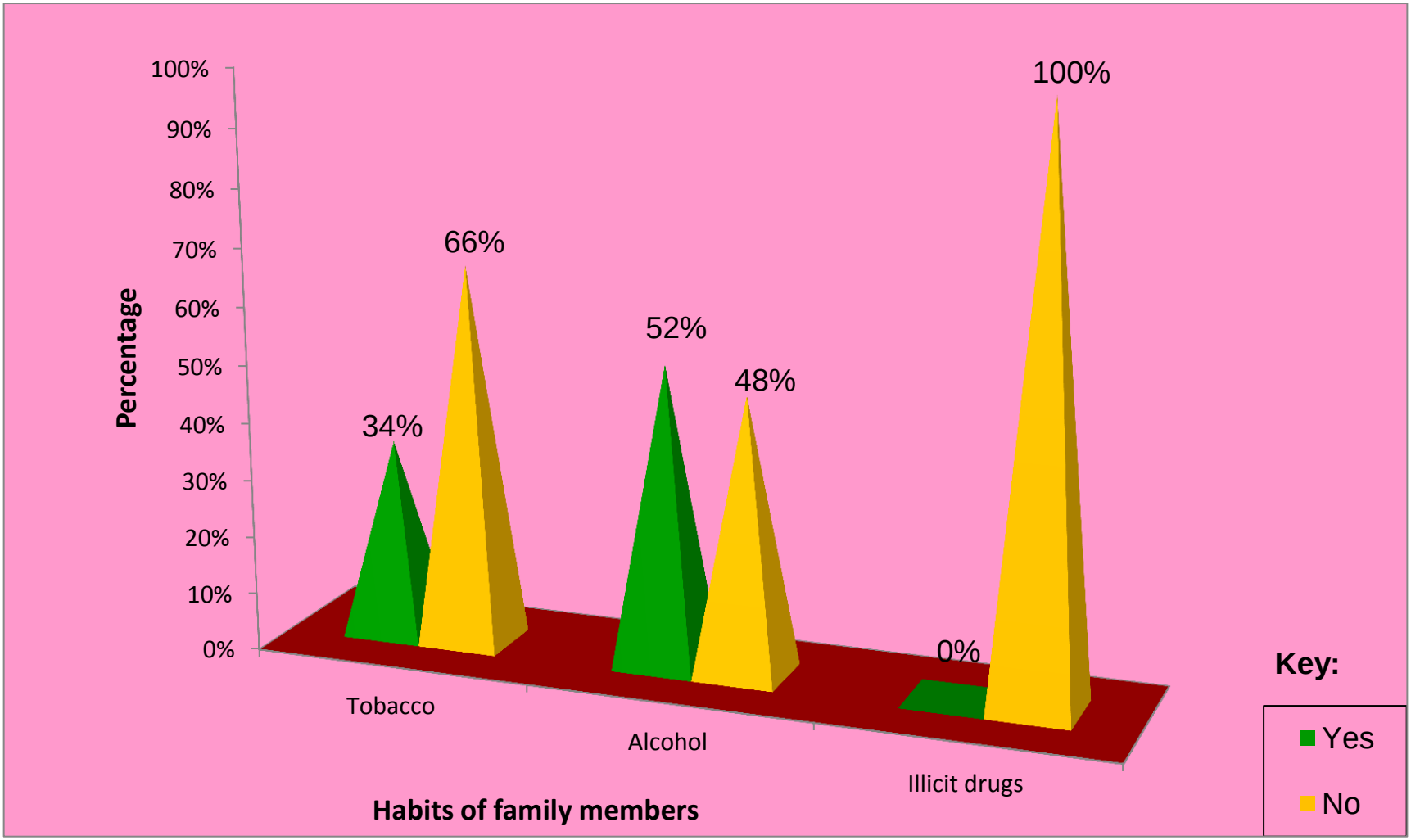


FIG 4.2: PERCENTAGE DISTRIBUTION OF ADOLESCENT BOYS BASED ON HABITS OF FAMILY MEMBERS

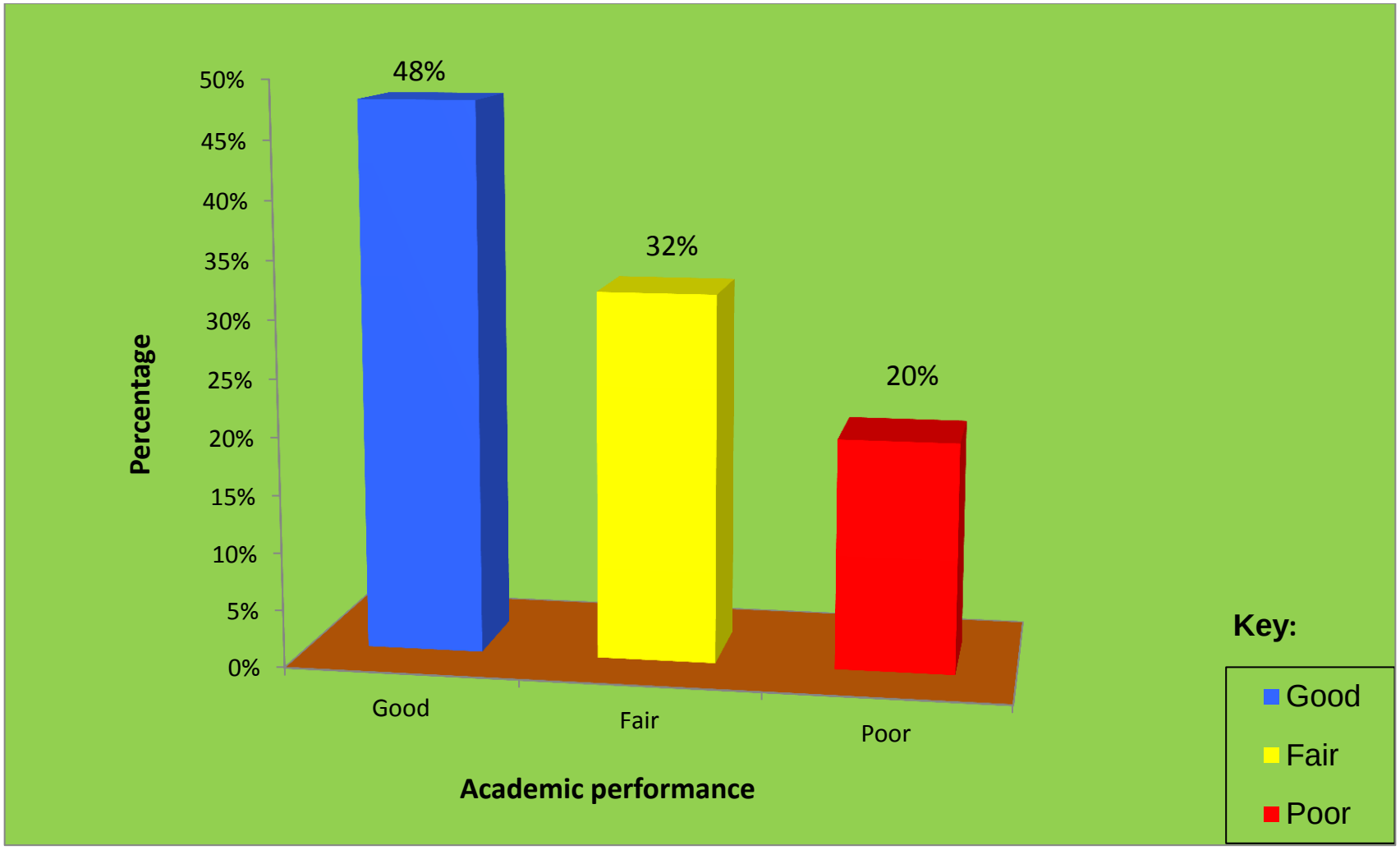


FIG 4.3: PERCENTAGE DISTRIBUTION OF ADOLESCENT BOYS BASED ON ACADEMIC PERFORMANCE

SECTION B: FREQUENCY AND PERCENTAGE DISTRIBUTION OF ASSESSMENT OF HIGH RISK BEHAVIOUR AMONG ADOLESCENTS BOYS

N=1OO

S.No	HIGH RISK BEHAVIOUR	FREQUENCY	PERCENTAGE
1.	**Habit of carrying harmful materials to the school** a) Yes b) No	0 100	0 100
2.	**Have you damaged school property** a) Yes b) No	0 100	0 100
3.	**Have you ever felt to be unsafe to go to familiar places in last 15 days** a) Yes b) No	0 100	0 100
4.	**Did someone has threatened or injured you anytime in the past 15 days** a) Yes b) No	0 100	0 100
5.	**Have an idea of running away from home in the past 15 days** a) Yes b) No	0 100	0 100

6.	**Did you ever feel so sad or hopeless almost every day for a week or more** a) Yes b) No	0 100	0 100
7.	**Did you ever seriously consider attempting suicide in the past 15 days** a) Yes b) No	0 100	0 100
8.	**Did you actually attempt suicide in the past 15 days** a) Yes b) No	0 100	0 100
9.	**Do you have the habit of smoking** a) Yes b) No	0 100	0 100
10.	**Do you have the habit of tobacco chewing** a) Yes b) No	0 100	0 100
11.	**Habit of consuming alcohol** a) Yes b) No	0 100	0 100
12.	**Did you ever had sexual intercourse with anyone else** a) Yes b) No	0 100	0 100
13.	**Have disregard your personal appearance** a) Yes b) No	15 85	15 85

14.	**Did you ever try to act out or be sensitive at home in the past 15days**		
	a) Yes	22	22
	b) No	78	78
15.	**Weight of the subjects**		
	a) Overweight	21	21
	b) Normal	79	79
16.	**Do you drive vehicle**		
	a) Yes	40	40
	b) No	60	60
	If yes, answer the following questions,		
16.1	**Did you use mobile phone while driving a vehicle (N=40)**		
	a) Yes	10	25
	b) No	30	75
16.2	**Did you violate traffic rules while driving a vehicle(N=40)**		
	a) Yes	34	85
	b) No	6	15
16.3	**Did you ride a vehicle after drinking alcohol(N=40)**		
	a) Yes	0	0
	b) No	40	100
16.4	**Did you wear helmet while drive a vehicle(N=40)**		
	a) Yes	15	37.5
	b) No	25	62.5

From table 4.3: shows the assessment of high risk behaviour among the adolescent boys.

With regards to high risk behaviour driving, of the total 100 subjects only 40 (40%) reported that they had driven vehicle in the past. Out of those 40, 10 (25%) said that they used mobile while driving, 34 (85%) reported violating traffic rules and 15 (37.5%) reported driving without helmet. None of the 40 subjects reported drunken drive.

In relation to carrying harmful materials to school, every subject (100%) reported that they did not carry harmful objects to school.

In relation to damaging school property, every subject (100%) reported that they have not damaged schoolproperty.

With respect to feeling unsafe in visiting familiar place, every subject (100%) reported they didn't felt like that in past.

While addressing about any threatening situation from strangers all the subjects (100%) reported they did not receive such threats from strangers.

In relation to feeling of running away from home, every subject (100%) reported that they didn't perceive in the past.

With respect to feeling of hopelessness every subject (100%) reported not experiencing such feeling in the past.

While asking subjects (100%) about attempting suicide, every subject reported they didn't attempted suicide in the past.

With respect to use of substance abuse like tobacco smoking and alcohol, every subject (100%) reported of not using any type of abusive substances.

In relation to the question did they ever felt a disregard about their personal appearance, 15 (15%) said that they do felt like that in the past 15 days.

In relation to the question, did they ever try to act out or to be sensitive at home, 22 (22%) reported they do expressed acting out behaviour in the past 15 days.

With respect to sexual high risk behaviour, every subject (100%) reported that they had not involved in any type of high risk sexual behaviour.

Regarding the question how they describe their weight, 21 (21%) said overweight, 79 (79%) said normal weight.

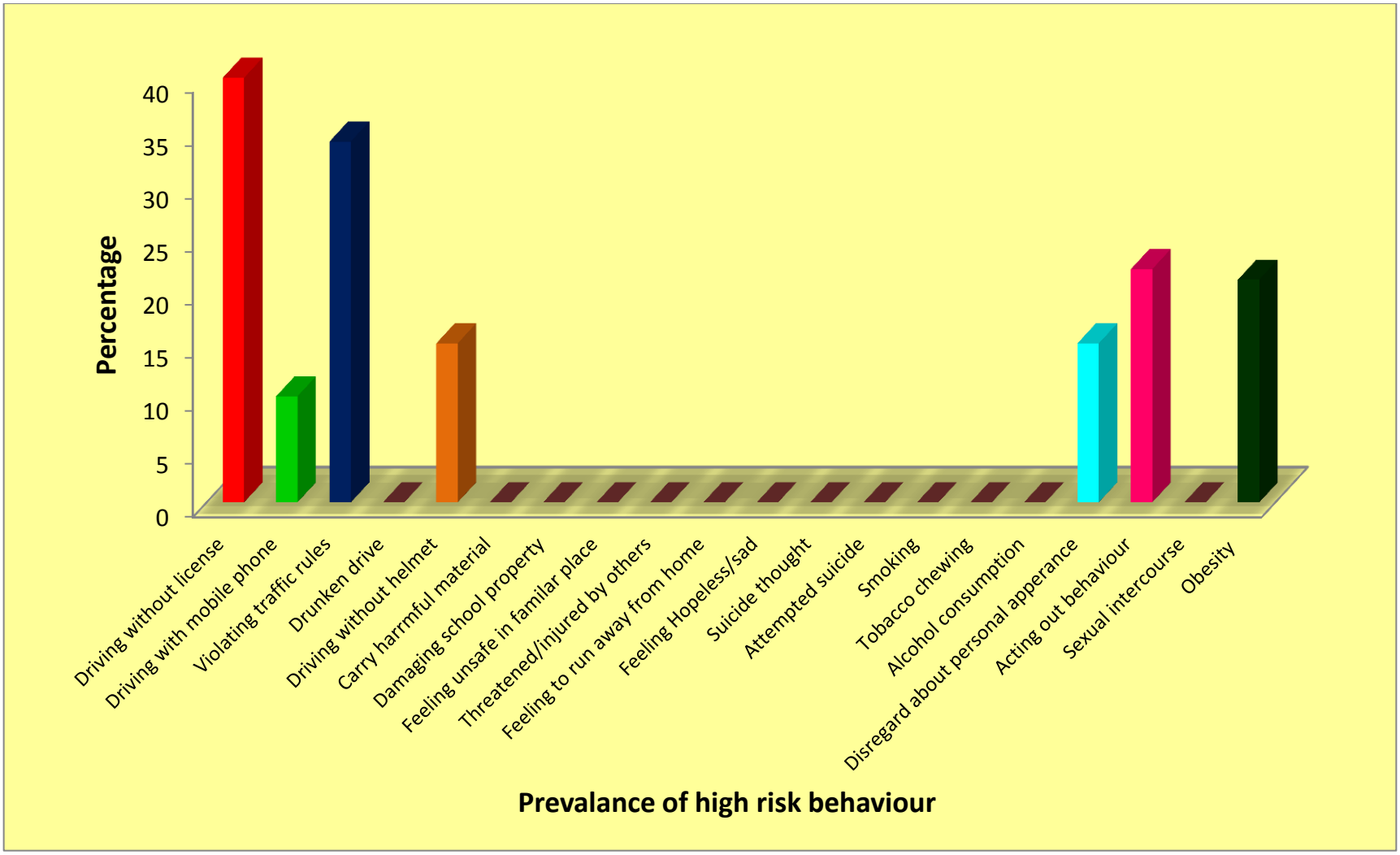


FIG 4.4: PERCENTAGE DISTRIBUTION BASED ON PREVALENCE OF HIGH RISK BEHAVIOUR

SECTION C: COMPARISON BETWEEN THE PRETEST AND POSTTEST LEVEL OF AWARENESS ABOUT HIGH RISK BEHAVIOUR AMONG ADOLESCENT BOYS

N=100

LEVEL OF AWARENESS	ADEQUATE AWARENESS		MODERATE AWARENESS		INADEQUATE AWARENESS		TOTAL	
	No	%	No	%	No	%	No	%
Pre test	0	0	39	39	61	61	100	100
Post test	56	56	44	44	0	0	100	100

Table 4.4 shows the level of awareness regarding high risk behaviours between the pretest and posttest. In the pretest among 100 adolescent boys none of the subjects had adequate awareness about high risk behaviour. 39 (39%) had moderately awareness, whereas 61 (61%) subjects had inadequate awareness. But following the behaviour change communication programme in the posttest 56 (56%) had adequate awareness, 44 (44%) subjects had moderately adequate awareness and none of them had inadequate awareness.

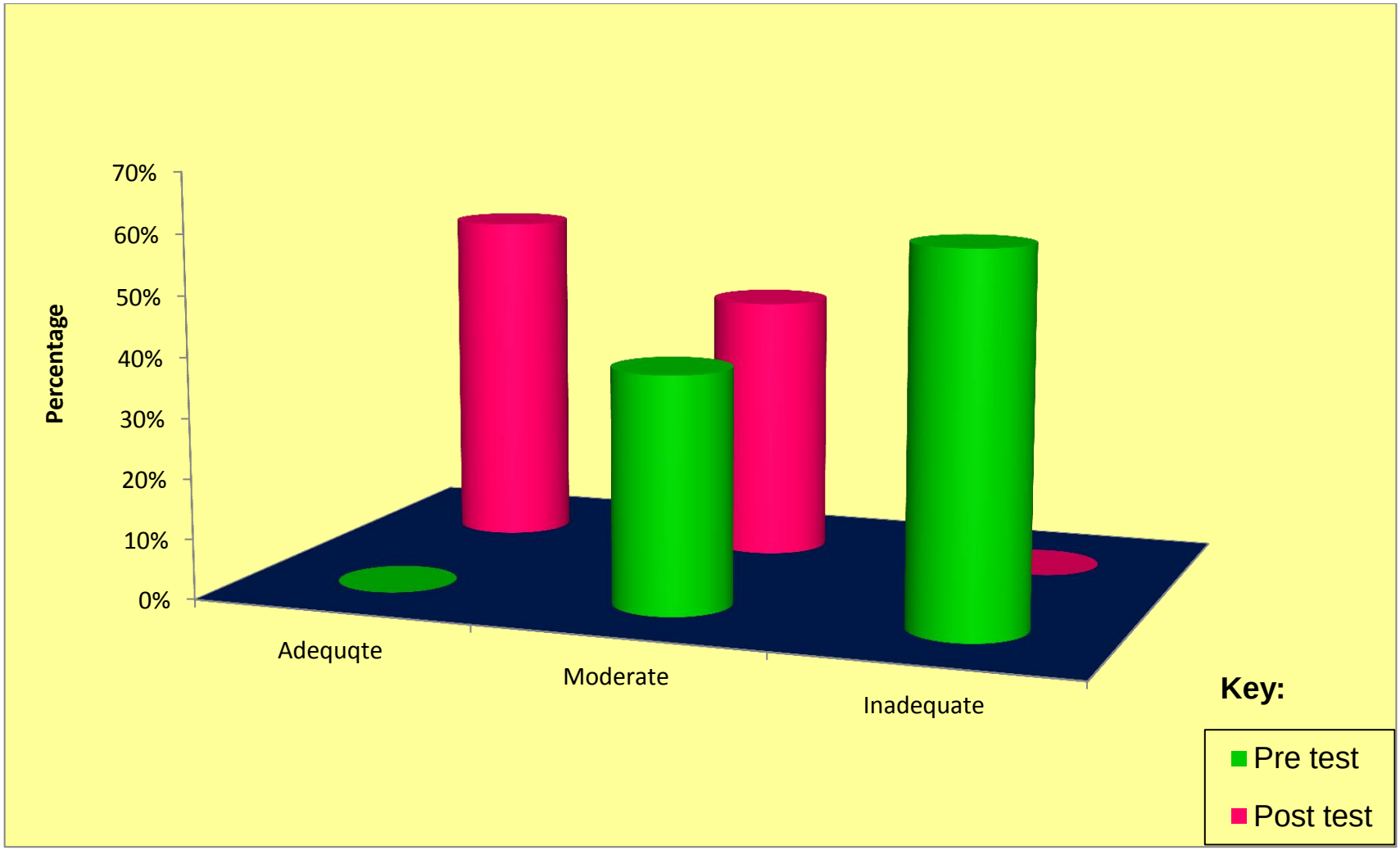


FIG 4.5: PERCENTAGE DISTRIBUTION OF ADOLESCENT BOYS BASED ON LEVEL OF AWARENESS ABOUT HIGH RISK BEHAVIOUR

SECTION D: COMPARISON BETWEEN THE MEAN AND STANDARD DEVIATION OF PRETEST AND POSTTEST SCORE ABOUT AWARENESS OF HIGH RISK BEHAVIOUR

S. NO	AWARENESS SCORE	MEAN	SD	CONFIDENCE INTERVAL	MEAN GAIN SCORE	t value
1	PRE TEST SCORE	13.67	3.09	13.08-14.25	9.22	23.70**
2.	POST TEST SCORE	22.89	1.97	22.50- 23.27		

** p <0.05

Table 4.5 shows that the overall mean of awareness regarding high risk behaviours among adolescent boys in the pretest was 13.67±3.09 with the confidence interval 13.08-14.25. After Behaviour change communication programme the awareness level was significantly improved in posttest with the mean awareness of 22.89±1.97 with the confidence interval 22.50-23.27. The mean gain score from pretest to post test was 9.22 which was found to be statistically significant at p value <0.05. Thus it shows that the Behavior change communication programme was effective.

SECTION E: ASSOCIATION OF LEVEL OF AWARENESS ABOUT HIGH RISK BEHAVIOUR WITH THE SELECTED DEMOGRAPHIC VARIABLES.

N=100

S. NO	DEMOGRAPHIC VARIABLE	AWARENESS LEVEL				χ^2 Value
		MODERATE		ADEQUATE		
		NO	%	NO	%	
1.	**Age**					
	a) 14 years	0	0	0	0	0.913 NS
	b) 15 years	19	19	11	11	
	c) 16 years	22	22	08	08	
	d) 17 years and above	29	29	11	11	
2.	**Educational level**					
	a) 10^{th}std	19	19	11	11	0.913 NS
	b) 11^{th}std	22	22	08	08	
	c) 12^{th}std	29	29	11	11	
3.	**Religion**					
	a) Hindu	48	48	24	24	1.905 NS
	b) Muslim	15	15	03	03	
	c) Christian	07	07	03	03	
	d) Others	0	0	0	0	
4.	**Monthly family income**					
	a) UptoRs.5000	47	47	18	18	2.117 NS
	b) Rs.5001-Rs.10000	18	18	07	07	
	c) Rs.10001-Rs. 20000	03	03	03	03	
	d) Rs. Above 20001	02	02	02	02	
5.	**Residence**					
	a) Rural	61	61	26	26	0.004 NS
	b) Urban	09	09	04	04	

6.	**Number of close friends** a) One b) Two c) Three d) Four	 14 31 15 10	 14 31 15 10	 08 12 06 04	 08 12 06 04	0.548 NS
7.	**Type of family** a) Joint b) Nuclear	27 43	27 43	11 19	11 19	0.032 NS
8.	**Caregiver** a) Parents b) Guardians	61 09	61 09	26 04	26 04	0.004 NS
9.	**Pocket money** a) Yes b) No	45 25	45 25	17 13	17 13	0.517 NS
10.	**Tobacco use in family** a) Yes b) No	25 45	25 45	09 21	09 21	0.306 NS
11.	**Alcohol use in family** a) Yes b) No	36 34	36 34	16 14	16 14	0.031 NS
12.	**Obesity in family** a) Yes b) No	12 58	12 58	06 24	06 24	0.116 NS
13.	**Academic performance** a) Good b) Fair c) Poor	 32 24 14	 32 24 14	 16 08 06	 16 08 06	0.635 NS

NS- Non significant

Table 4.6 shows the association of the demographic variables like age, class, religion, family income, number of close friends, type of family, part time job, living with caregiver, receiving pocket money, family members using alcohol, smoking, illicit substance, obesity in family members and academic performance of subjects .

While exploring the association between the above demographic variables with awareness of high risk behaviour none of the variables had association with awareness of the subjects. Hence the effectiveness of Behaviour change communication programme was independent of all the demographic variables.

SECTION F: ASSOCIATION OF LEVEL OF AWARENESS WITH THE HIGH RISK BEHAVIOUR

N=100

S. NO	HIGH RISK BEHAVIOUR	AWARENESS LEVEL		χ^2 value	P value
		MODERATE	ADEQUATE		
1.	**Using mobile while driving (N=40)**				
	a) Yes	03	07	3.85	0.05**
	b) No	13	17		S
2.	**Violate traffic rules (N=40)**				
	a) Yes	12	22	0.989	NS
	b) No	04	02		
3.	**Driving without helmet (N=40)**				
	a) Yes	09	06	2.778	NS
	b) No	07	18		
4.	**Disregard about personal appearance**				
	a) Yes	06	09	0.003	NS
	b) No	38	47		
5.	**Acting out behaviour**				
	a) Yes	09	13	0.008	NS
	b) No	35	43		
6.	**Obesity**				
	a) Yes	10	11	0.017	NS
	b) No	34	45		

** p <0.05, NS - Non Significant.

Table 4.7 depicts the association between the high risk behaviour and level of awareness about high risk behaviour. While trying to find association between level of awareness of high risk behaviour and the presence high risk behaviour such as driving while using mobiles, driving without helmet, violation of traffic rules, disregard about personal behaviour, acting out behaviour, and obesity,Only mobile phone usage while driving had a significant association. i.e. those who had reported using mobile while driving in the past are more likely to have adequate knowledge than who did not used mobile while driving. No association could be found for other high risk behaviour and level of awareness.

CHAPTER-V

RESULTS AND DISCUSSION

CHAPTER – V

RESULTS AND DISCUSSION

The study was conducted to determine the effectiveness of Behaviour change communication programme on awareness of high risk behaviours among adolescent's boys in government higher secondary school, Acharapakkam. A quasi experimental one group pretest –posttest design was adopted for this study.

A total number of 100 subjects were selected for the study. All the participants completed a pretested questionnaire at baseline and received a Behaviour change communication programme by the investigator following to that a posttest assessment was made at the end of seventh day. Overall Behaviour change communication programme was found as effective.

In the present study the prevalence of high risk behaviour was as follows: driving while using mobile (25%), violating traffic rules while driving (85%), driving without helmet (37.5%), disregard with personal appearance (15%), acting our behaviour (22%), and obesity (21%).

The prevalence of acting out behaviour among the adolescents in the present study was found to be comparably higher (22%) with the finding of **John C. Ball et al, (2009)** who found the only 4.3 % of subjects displaying acting out behaviour. This may be attributed to cultural factors prevailing in our Indian society. Another reason may be lower sample size which we adopted in the present study, which may have resulted in narrowed distribution of the subject's characteristics.

Another important aspect which was identified in present study was about the careless driving behaviour among adolescents i.e. Driving while using mobile (25%), violating traffic rules while driving (85%), driving without helmet (37.5%). A similar result was documented by **Jeffrey Jensen (2007).**

Obesity (21%) and disregard with personal appearance (15%) was fond to be relatively higher in the present study, which was congruent with the finding of **Ghosh A (2011)** and **Misra A, Shah P, (2011).** Though the relation between above two high risk behaviour are not statistically computed, it is a well-known fact that obese people are more likely to suffer from self-esteem problem. Obesity is a potentially preventable high risk behaviour which may have a positive outcome in the student's social life.

Awareness about high risk behaviour was also measured in the present study which indicated aa lower level of awareness in the baseline. Following to an intervention behaviour change communication awareness level of the subjects significantly improved. The results of this study indicated behaviour change communication may serve as a better aid in reducing high risk behaviour among adolescents. Most of the previous studies done in this area employed one or another intervention to test the effect of it in long term basis. i.e. change in high risk behaviour, but no steps was taken in previous studies to enhance the knowledge about high risk behaviour, which is very essential to change a person's perception.

Another noteworthy information about the study was the association which was found between using mobile phone while driving in the past and the improved awareness core in the post test. This indicated that the person who actually involved in the high risk behaviours benefitted by this intervention a lot than who were not involved. This can be considered in future, focusing this intervention only on those with high risk behaviour.

One potential limitation in the present study could be self-reported data collection method, which may have played a role in

underreporting of many high risk behaviours which was previously reported in the literature like, smoking, alcohol abuse, sexual activity etc. This can be overcome in the future study by adopting a more rigorous and confidential data collection method.

CHAPTER-VI

SUMMARY AND CONCLUSION

CHAPTER – VI

SUMMARY AND CONCLUSION

SUMMARY

The present study was conducted to assess the prevalence of high risk behaviour and to test the effectiveness of Behaviour change communication programme on enhancing the awareness of high risk behaviour among adolescent boys.

In the present study the prevalence of high risk behaviour was as follows: driving while using mobile (25%), violating traffic rules while driving (85%), driving without helmet (37.5%), disregard with personal appearance (15%), acting our behaviour (22%), and obesity (21%).

The Behaviour change communication which was tested in improving the awareness in the present study was to be statistically significant with p value <0.05.

The high risk behaviour using mobile phone in the past had a significant association with the level of awareness ($p<0.05$) of high risk behaviour.

Others variables did not had a correlation with the level of awareness of high risk behaviour.

CONCLUSION

A simple Behaviour change communication programme has been proved to be effective in improving awareness of high risk behaviour in the present study. This intervention may serve as an effective tool in reducing high risk behaviour among the adolescents, which in turn may reflect ultimately on the national overall productivity.

NURSING IMPLICATIONS

The findings of the present study have implications in the field of Nursing education, Nursing service, Nursing administration and Nursing research.

1. The present study can help nurses to enrich their awareness on high risk behaviour and its prevention among adolescent boys.

2. Helps nurses to identity the underlying causes of high risk behaviour by collection of detail history from adolescent boys.

3. Understanding the needs of adolescent boys who are having behaviour problems which may help nurse to plan and provide appropriate nursing care.

NURSING EDUCATION

1. Train nurses to provide Behaviour communication programme in various aspects of high risk behaviour.

2. Student Nurses can be taught about the awareness of high risk behaviour.

3. The organization of continuing education programmes to enhance awareness on high risk behaviour and its management.

NURSING SERVICE

1. To utilize the tool for assessing the behavioural problems of adolescents in school.

2. Behaviour communication programme can be given to parents and guardians to take care of the adolescents.

3. Emphasis on rehabilitation of the adolescents and follow up to prevent further complications.

4. Encourage staff nurse to undergo short term Behaviour change communication programme.

NURSING ADMINISTRATION

1. Nurse administrators can impose the routine teaching of Behaviour communication for adolescents in school.

2. Nursing administrators can frame new policy and protocols for managing high risk behaviour.

3. Separate health programme with sufficient staff, materials and facilities like Behaviour communication programme should be organized in schools.

4. Administration can organize staff development programmes such as Continuing Nursing Education, working and inservice education programmes for nurses.

5. Making advertising through mass education on high risk behaviour for adolescents in schools.

NURSING RESEARCH

Nurse Researchers should challenge to perform scientific work and take part in application and evaluation of effectiveness of Behaviour change communication programme among adolescents with high risk behaviour.

1. This study shows the awareness about the behaviour problem and its management among adolescents.

2. The study reveals the sound awareness of the nurse in observation of high risk behaviour tools for adolescents.

3. The study is preliminary step for exploring the concept of nursing and involved nursing care with respect to the involvement of prevention of high risk behaviour among adolescents.

4. True experimental studies can be done.

5. Further investigator can use this study as a reference material.

6. The study provides awareness for further studies among the student in this area.

RECOMMENDATIONS

1. The study can be done in comparing with other age group or any associated problems with other behaviours.

2. The study can be done in large samples.

3. The study can be conducted in individuals in a particular school to find out the influence of environmental factors for behaviour problems.

4. A comparative study can be done between the high risk behaviour of rural and urban adolescents.

5. A descriptive study to assess the awareness, attitude and practice regarding various aspects of behaviour problems among adolescents.

6. This study can be done as a longitudinal study with many data collection period after the intervention to know the long lasting effect of this intervention.

BIBLIOGRAPHY

BIBLIOGRAPHY

BOOK REFERENCE

1. Ahuja N.Textbook of postgraduate psychiatry.4th edition.Newdelhi: Jaypee brothers medical publishers;2004.
2. Alligard MR.Nursing theroists and their work.6thedition.Mosby company;2003.
3. Basavanthappa BT.Nursing research.5thedition.Newdelhi: jaypee brothers;2007.
4. David J.Alcoholism and treatment. 2ndedition. Newyork:johnwilley publishers;1998.
5. Danis DD. Peer pressure and motivation of alcoholicand drug dependent.jayee brothers;2007.
6. Edward S.Textbookofmedicine.19th edition.LBS publication;2002.
7. Furtinash M Katherne .Psychiatric nursing. first edition, mosby publications;1996.
8. Fox david. Fundamentals of research in nursing. 4th edition. Newyork: Appleton centre crafts;1993.
9. Gupta SP.Statistical methods.28th edition.Newdelhi:sultan and sons publishers;1998.
10. Haber. Psychiatric nursing.5th edition.mosby publications; 2000.

11. Kaplan and Sadock. Synopsis of psychiatry,behavioral sciences/ clinical psychiatrics.10th edition.Lippincott Williams and wilkins;2007.

12. Kothari CR. Research methodology methodsand techniques. 2nd edition.Newdelhi: wishwaprakasam;1990.

13. Laraia Stuart .Principles and practice of PsychiatricNursing. 8th edition.Kundli: Elsevier;2005.

14. Laura A. Principles and practice of NursingResearch. Mosby publications;2001.

15. Lousie.Basic concepts of Psychiatric MentalHealth Nursing.7th edition.Newdelhi: wilkins Williams publishers;2008.

16. Mahaja BK.Methods of biostatistics. Newdelhi: jaypee brothers publishers;1994.

17. Mary Ann Boyd, Psychiatric nursing contemporarypractice.3rd edition. Newdelhi:Lippincott publication;2005.

18. Mary C Townsend. Psychiatric health Nursing.5th edition. Newdelhi :jaypee brothers;2006.

19. Mohr K Wanda.Psychiatriy Mental health Nursing. 6th edition, Phiadelphia:2006.

20. MorrenFrisch .Principles and practice ofPsychiatric Nursing. 2nd edition.Newdelhi: Delmar publishers;2006.

21. Polit D.F. Nursing research principles and methods. 6th edition. Philadelphia: Lippincott;1999.

22. Porland. Nursing research.6th edition. Philadelphia: Lippincott publications;2000.

23. Potter AP,PerryAG.Fundamentals ofnursing.4thedition.mosby Louis publications;2007.

24. Sally wechneier .Oxford advanced learners dictionary.6th edition.Newyork: oxford dictionary university;2000.

25. Sheila. Psychiatric nursing.3rd edition.Philadelphia:Lippincott publications;

26. Townsend CM. Psychiatric health nursing concepts ofcare. 1st edition. California: library of congress;1993.

JOURNAL REFERENCES

1) Ana Rute Cardoso, DorteVerner. Youth Risk-Taking Behaviour in Brazil: Drug Use and Teenage Pregnancies.IZA Discussion series paper.2007.1-14.
2) Aplasca MR, et al.,Results of a model AIDS prevention program for high school students in the Philippines. AIDS. 1995 Jul;9Suppl 1:S7-13.
3) Aseltine RH Jr, DeMartino R. An outcome evaluation of the SOS Suicide Prevention Program. Am J Public Health. 2004 Mar;94(3):446-51.
4) Basch, C.E. (2010). Healthier Students Are Better Learners: A Missing Link in Efforts to Close the Achievement Gap . Equity Matters: Research Review No. 6. New York: The Campaign for Educational Equity.
5) Boon B, et al.,alcohol use in male adults through computer generated personalized advice: randomized controlled trial. J Med Internet Res. 2011 Jun 30;13(2):e43.
6) Centers for Disease Control and Prevention. The association between school based physical activity, including physical education, and academic performance. Atlanta, GA: U.S. Department of Health and Human Services; 2010

7) Caria MP, et al.,EU-Dap Study Group. Effects of a school-based prevention program on European adolescents' patterns of alcohol use. J Adolesc Health. 2011 Feb;48(2):182-8.

8) Crooks CV, et al.,mpact of a universal school-based violence prevention program on violent delinquency: distinctive benefits for youth with maltreatment histories.

9) Child Abuse Negl. 2011 Jun;35(6):393-400. Epub 2011 Jun 8.

Cusimano MD, Sameem M. The effectiveness of middle and high school-based suicide prevention programmes for adolescents: a systematic review. Inj Prev. 2011 Feb;17(1):43-9. Epub 2010 Nov 7.

10) Howard J, Friend D, Parker T, Streker G. Use of SMS to support parents who experience violence from their adolescents.Aust J Prim Health. 2010;16(2):187-91.

11) Irwin, C. E., Jr. (1993). Adolescence and risk taking: How are they related? In N. J. Bell & R. W. Bell (Eds.), Adolescent risk taking (pp. 7-28). Newbury Park, CA: Sage Publications.

12) King KA, Strunk CM, Sorter MT. Preliminary effectiveness of surviving the teens(®) suicide prevention and depression awareness program on adolescents' suicidality and self-efficacy in performing help-seeking behaviours. JSch Health. 2011 Sep;81(9):581-90. doi: 10.1111/j.1746-1561.2011.00630.x.

13) Kirby D, Obasi A, Laris BA. The effectiveness of sex education and HIV education interventions in schools in developing countries.World Health Organ Tech Rep Ser. 2006;938:103-50; discussion 317-41.

14) Klepp KI, et al., AIDS education in Tanzania: promoting risk reduction among primary school children.Am J Public Health. 1997 Dec;87(12):1931-6.

15) Mehta RK, Tandon N, Singh Y, Agarwal R, Mani K, Grewal K. A study of growth parameters and prevalence of overweight and obesity in school children from Delhi. Indian Pediatr. 2006;43:943–52.

16) Nair MK, Paul MK, Leena ML, Thankachi Y, George B, Russell PS, Pillai HV. Effectiveness of a Reproductive Sexual Health Education Package among School Going Adolescents. Indian J Pediatr. 2011 May 27.

17) Oyo-Ita AE, Ikpeme BM, Etokidem AJ, Offor JB, Okokon EO, Etuk SJ. Knowledge of HIV/AIDS among secondary school adolescents in Calabar-Nigeria. Ann Afri Med 2005;4:2-6.

18) Ramachandran A, Snehalatha C, Vinitha R, Thayyil M, Kumar CK, Sheeba L, et al. Prevalence of overweight in urban Indian adolescent school children. Diabetes Res ClinPrac. 2002;57:185–90.

19) Sidhu S, Kaur N, Kaur R. Overweight and obesity in affluent school children. Ann Hum Biol.2006;33:255–9

20) Taras H. Nutrition and student performance at school. Journal of School Health2005;75(6):199–213.

21) Thomas.R. School-based programme for preventing smoking. Cochrane Database Syst Rev. 2002;(4):CD001293..

22) Yates, J. F., & Stone, E. R. (1992). The risk construct. In J.F. Yates, (Ed.), Risk taking behaviour(pp. 1-26) New York: Wiley.

APPENDICES

PART-I

DEMOGRAPHIC PROFORMA

1. How old you are_____

   a. 14years
   b. 15 years
   c. 16years
   d. 17years and above

2 .which class you are studying _____

   a. 10^{th} std
   b. 11^{th} std
   c. 12^{th} std

3. Which religion you belongs to_____

   a. Hindu
   b. Christian
   c. Muslim
   d. Others

4. Monthly family income

   a. Up to 5000
   b. 5001-10000
   c. 10001- 20000
   d. Above 20001

5. Place of residence

   a. Rural
   b. Urban

6. Number of close friends_____ (No's)

7. Type of family

a. Joint
b. Nuclear

8. Are you doing any part time job?

a. Yes
b. No

9. With whom you are living

a. Parents
b. Guardians

10. Receive pocket money daily

a. Yes
b. No

11. Does anyone in your family use tobacco (smoking or chewing?)

a. Yes
b. No

12. Does anyone in your family use alcohol _____

a. Yes
b. No

13. Does anyone in your family use any illicit drugs?

a. Yes
b. No

14. Does anyone in your family is obese?

a. Yes
b. No

15. Rate your own academic performance?

a. Good
b. Fair
c. Poor

PART-II : QUESTIONNAIRE ON ASSESSMENT OF HIGH RISK BEHAVIOUR

1. Do you drive vehicle (includes bicycle, motor vehicle, and others)

a. Yes
b. No

If yes answer the following questions which has taken place in the past 30 days

1.1. Did you use mobile phone while driving a vehicle?

a. Yes
b. No

1.2. Did you violate traffic rules while driving a vehicle?

a. Yes
b. No

1.3. Did you ride a vehicle after drinking alcohol?

a. Yes
b. No

1.4. Did you wear helmet while drive a vehicle?

a. Yes
b. No

2. Did you carry any harmful materials (such as a blade, knife) to school in the past 30 days?

a. Yes
b. No

3. Did you ever damage your school property in the past 30 days?

a. Yes
b. No

4. Did you ever felt unsafe to go to some place which was very familiar to you in the past 30 days?

a. Yes
b. No

5. Did someone has threatened or injured you anytime in the past 30 days?

a. Yes
b. No

6. Did you ever have an idea of running away from home in the past 30 days?

a. Yes
b. No

7. During the past 30 days did you ever feel so sad or hopeless almost every day for a week or more?

a. Yes
b. No

8. Did you ever seriously consider attempting suicide in the past 30 days?

a. Yes
b. No

9. Did you actually attempt suicide in the past 30 days?

a. Yes
b. No

10. Did you smoke cigarette or beedi in the past 30 days?

a. Yes
b. No

11. Did you consume chewable tobacco (pan, ghutka etc) in the past 30 days?

a. Yes
b. No

12. Did you consume alcohol in the past 30 days?

a. Yes
b. No

13. Did you ever felt a disregard about your personal appearance in the past 30 days?

a. Yes
b. No

14. Did you ever try to act out or be sensitive at home in the past 30 days?

a. Yes
b. No

15. Did you ever have a sexual intercourse in the past 30 days?

a. Yes
b. No

If yes answer the following

15.1. Did you or your partner use a condom during the intercourse?

a. Yes
b. No

15.2. Did you drink alcohol or use drugs before you had sexual intercourse last time?

a. Yes
b. No

16. How do you describe your weight?

a. Over weight
b. correct weight

PART-III: AWARENESS QUESTIONNAIRE ON HIGH RISK BEHAVIOUR

1. Which of the following may endanger your life while driving?

    a. Riding a vehicle with helmet
    b. Driving vehicle with alcohol
    c. Driving a geared vehicle
    d. Driving in national high way

2. While driving you can be sued by law under which of the following?

    a. Driving without license
    b. Driving with 2 members in a bike
    c. Driving in an U turn
    d. Driving in mountains

3. Which of the following may lead to death of an individual while driving?

    a. Driving while using cell phone
    b. Driving in a 2 way road
    c. Driving with friends
    d. Driving a geared vehicle

4. Driving without helmet may lead to?

    a. Nuisance due to noise
    b. Nasal irritation due to inhaling smoke fumes
    c. Head injury
    d. Difficult to see an object

5. Smoking cigarette /beedi may lead to which of the following?

a. Lung cancer
b. Headache
c. Stomach ache
d. Liver failure

6. Chewing tobacco may lead to which of the following?

a. Kidney failure
b. Poor appetite
c. Vision problem
d. Oral cancer

7. Smoking in public places in an offence in our country?

a. Yes
b. No

8. Which of the following has high alcohol content?

a. Beer
b. Wine
c. Brandy
d. Toad

9. Alcoholic driving may lead to?

a. Road traffic accident
b. Generalized body pain
c. Hypertension
d. Vision problem

10. Prolonged alcohol intake may lead to?

a. Chronic leg pain
b. Addiction problem
c. Lung cancer
d. Osteoporosis

11. Which system of the body is most often affected by chronic alcohol intake?

a. Liver
b. Kidney
c. Spleen
d. Lung

12. Which of the following in an offence in school premises?

a. Carrying a knife to School
b. Carrying a sharpened pen
c. Talking with girls
d. Oral quarrel with friends

13. Injuring a fellow student physically is violence?

a. Yes
b. No

14. Which of the following is a punishment which may be given for violent behavior?

a. Admission in a delinquent home
b. Seclusion
c. Fine /penalty
d. Failing in subjects

15. Trying to end our own life is an offense in our country?

a. Yes
b. No

16. Which of the following is a symptom of suicidal behavior?

a. Hopelessness
b. Poor appetite
c. Angry behavior
d. Head ache

17. Attempted suicide in India may extend a punishment of?

a. Imprisonment of not less than 1 year
b. Fine of 10 lakhs
c. Seclusion
d. None of the above

18. The following behavior may lead to AIDS?

a. Mouth to mouth kissing a person affected with AIDS
b. Hugging a person affected with AIDS
c. Sexual intercourse with person affected with AIDS
d. None of the above

19. Which of the body fluids may be a source for HIV infection?

a. Blood
b. Semen
c. Vaginal fluid
d. All of the above

20. Which of the following behavior protect from sexually transmitted infection?

a. Washing genital organs after intercourse
b. Using condom
c. Taking antibiotics after intercourse
d. Taking a birth pill before intercourse

21. Which of the following can lead to Teenage Pregnancy?

a. Unprotected intercourse without condoms
b. Intercourse without birth pills
c. Poor knowledge about reproduction
d. All of the above

22. Does AIDS can be cured?

a. Yes
b. No

23. Sharing injection between drug users may lead to?

a. Hepatitis & HIV
b. Cirrhosis of liver
c. Vision problem
d. None of the above

24. Drug abuse may lead to which of the following?

a. Withdrawal symptoms
b. Nutrition deficiency
c. Obesity
d. Physical fatigue

25. Which of the following is an illicit drug in India?
    a. Cannabis
    b. Heroin
    c. Cocaine
    d. All of the above
26. Using heroin is an illegal activity in India?
    a. Yes
    b. No
27. Obesity is an important risk factor for?
    a. Coronary heart disease
    b. Liver failure
    c. Kidney failure
    d. Pancreas cancer
28. Which of the following is a high fatty food?
    a. Ghee
    b. Milk
    c. Butter milk
    d. Curd
29. Which of the following behavior is a reason for obesity?
    a. Poor physical activity
    b. Eating lot of fruits
    c. Eating lot of vegetables
    d. None of the above
30. Which of the may prevent obesity?
    a. Consuming high fiber rich diet
    b. Aerobic exercise
    c. Avoiding fatty foods
    d. All of the above

PART-III

KEY ANSWER

Q.NO	ANSWER	Q.NO	ANSWER
1	A	16	A
2	A	17	A
3	A	18	C
4	C	19	B
5	A	20	B
6	D	21	D
7	A	22	B
8	C	23	A
9	A	24	A
10	B	25	D
11	A	26	A
12	A	27	A
13	A	28	A
14	A	29	A
15	A	30	D

பகுதி – அ

தனிநபர் விபரம்

1. வயது

   அ. 14 வயது

   ஆ. 15 வயது

   இ. 16 வயது

   ஈ. 17 – வயது அல்லது அதற்கு மேல்

2. மாணவர் பயிலும் வகுப்பு

   அ. பத்தாம் வகுப்பு

   ஆ. பதினொறாம் வகுப்பு

   இ. பன்னிரெண்டாம் வகுப்பு

3. மதம்

   அ. இந்து

   ஆ. கிறிஸ்துவர்

   இ. முஸ்லீம்

   ஈ. மற்றவர்

4. குடும்பத்தின் மாத வருமானம்

   அ. ரூ.3000/– வரை

   ஆ. ரூ.3001/– ரூ.5000/–வரை

   இ. ரூ.5001/– ரூ.10000/– வரை

   ஈ. ரூ.10001 அதற்கு மேல்

5. வசிக்கும் இடம்

   அ. கிராமப்புறம்

   ஆ. நகர்ப்புறம்

6. உங்கள் நண்பர்களின் எண்ணிக்கை .....

7. குடும்ப அமைப்பு

   அ. தனிக்குடும்பம்

   ஆ. கூட்டுக்குடும்பம்

8. நீங்கள் எங்கேயாவது பகுதி நேரமாக பணிபுரிகிறீர்களா

   அ. ஆம்

   ஆ. இல்லை

9. உங்களுடன் வசிப்பது

அ. பெற்றோர்கள்

ஆ. பாதுகாவலர்கள்

10. நீங்கள் கைசெலவிற்க்கு தினமும் பணம் வாங்குவீர்களா

அ. ஆம்

ஆ. இல்லை

11. உங்கள் குடும்பத்தில் உள்ள நபர்களில் யவரேனும் புகையிலை போடும் பழக்கம் உள்ளவர்களா

அ. ஆம்

ஆ. இல்லை

12. உங்கள் குடும்பத்தில் உள்ள நபர்களில் யவரேனும் மது அருந்தும் பழக்கம் உள்ளவர்களா

அ. ஆம்

ஆ. இல்லை

13. உங்கள் குடும்பத்தில் உள்ள நபர்களில் யவரேனும் போதை பொருட்கள் எடுத்துக்கொள்கிறார்களா

அ. ஆம்

ஆ. இல்லை

14. உங்கள் குடும்பத்தில் யாரேனும் உடல்பருமனாக உள்ளார்களா

அ. ஆம்

ஆ. இல்லை

15. பள்ளியில் உங்களின் செயல்பாடு

அ. மிக நன்று

ஆ. நன்று

இ. மோசமான

பகுதி-ஆ

அபாயகரமான செயல்பாடுகளை பற்றி அறிவதற்கான வினாக்கள்

1. நீங்கள் இருசக்கர வாகனம் ஓட்டுவீர்களா?

அ. ஆம்

ஆ. இல்லை

ஆம் என்றால் கீழ்வரும் வினாக்களுக்கு பதிலளிக்கவும்

1.1 நீங்கள் இருசக்கர வாகனம் ஓட்டும் பொழுது கைபேசியை உபயோகப்படுத்துவீர்களா?

அ. ஆம்

ஆ. இல்லை

1.2 நீங்கள் இருசக்கரவாகனம் ஓட்டும் பொழுது சாலை விதிகளை பின்பற்றுவீர்களா?

அ. ஆம்

ஆ. இல்லை

1.3 நீங்கள் மது அருந்துவிட்டு இருசக்கர வாகனம் ஓட்டுவீர்களா?

அ. ஆம்

ஆ. இல்லை

1.4 நீங்கள் இருசக்கர வாகனம் ஓட்டும் பொழுது தலைகவசம் பயன்படுத்துவீர்களா?

அ. ஆம்

ஆ. இல்லை

2. நீங்கள் கடந்த 30 நாட்களில் பள்ளிக்கு அபாயகரமான பொருட்களை எடுத்து வந்துள்ளீர்களா? (கத்தி, பிளேடு முத– யன)

அ. ஆம்

ஆ. இல்லை

3. கடந்த 30 நாட்களில் நீங்கள் பள்ளிக்குச் சொந்தமான பொருளை சேதப்படுத்தியுள்ளீர்களா?

அ. ஆம்

ஆ. இல்லை

4. நீங்கள் கடந்த 30 நாட்களில் நன்கு பழக்கப்பட்ட இடங்களுக்கு பாதுகாப்பு இல்லை என கருதி செல்லமால் இருந்தது உண்டா?

அ. ஆம்

ஆ. இல்லை

5. கடந்த 30 நாட்களில் உங்களால் யாரேனும் தாக்கப்பட்டுள்ளார்களா?

அ. ஆம்

ஆ. இல்லை

6. கடந்த 30 நாட்களில் நீங்கள் வீட்டைவிட்டு வேறு எங்காவது செல்ல வேண்டுமென்று எப்பொழுதாவது நினைத்தது உண்டா?

அ. ஆம்

ஆ. இல்லை

7. கடந்த 30 நாட்களில் ஒருவாரமோ அதற்கு மேலாகவோ மனவருத்தத்துடனோ அல்லது மனஉலைச்சலுடனோ இருந்துள்ளீர்களா?

அ. ஆம்

ஆ. இல்லை

8. கடந்த 30 நாட்களில் நீங்கள் தற்கொலை செய்து கொள்ள வேண்டும் என நினைத்துள்ளீர்களா?

அ. ஆம்

ஆ. இல்லை

9. கடந்த 30 நாட்களில் நீங்கள் தற்கொலை முயற்சியில் ஈடுபட்டுள்ளீர்களா?

அ. ஆம்

ஆ. இல்லை

10. கடந்த 30 நாட்களில் நீங்கள் புகைபிடித்துள்ளீர்களா?

அ. ஆம்

ஆ. இல்லை

11. கடந்த 30 நாட்களில் நீங்கள் புகையிலை பயன்படுத்தியது உண்டா?

அ. ஆம்

ஆ. இல்லை

12. கடந்த 30 நாட்களில் மதுபானம் அருந்தியது உண்டா?

அ. ஆம்

ஆ. இல்லை

13. கடந்த 30 நாட்களில் நீங்கள் உங்களது உடல் தோற்றத்தை கண்டு வருத்தப்பட்டுள்ளீர்களா?

அ. ஆம்

ஆ. இல்லை

14. கடந்த 30 நாட்களில் நீங்கள் எதற்காகவாது உங்கள் வீட்டில் கோபப்பட்டோ அல்லது எதையாவது மறைத்ததோ உண்டா?

அ. ஆம்

ஆ. இல்லை

15. கடந்த 30 நாட்களில் நீங்கள் உடலுறவு கொண்டுள்ளீர்களா?

அ. ஆம்

ஆ. இல்லை

ஆம் என்றால் பின்வரும் வினாக்களுக்கு பதிலளிக்கவும்

15.1. உடலுறவின் போது யாரேனும் ஒருவர் பாதுகாப்பு உறை பயன்படுத்தினீர்களா

அ. ஆம்

ஆ. இல்லை

15.2. நீங்கள் கடைசியாக உடலுறவு கொண்ட போது மதுபானமோ அல்லது போதைபொருட்களோ எடுத்துக்கொண்டீர்களா?

அ. ஆம்

ஆ. இல்லை

16. உங்கள் உடல் எடையை எப்படி மதிப்பிடுவீர்கள்?

அ. அதிக எடை

ஆ. சராசரி எடை

பகுதி– இ

விழிப்புணர்வு பற்றிய வினாக்கள்

1. இருசக்கர வாகனம் ஓட்டும்பொழுது எது பாதுகாப்பானது

அ. தலைகவசம் அணிந்து வாகனம் ஓட்டுவது

ஆ. மது அருந்திவிட்டு வாகனம் ஓட்டுவது

இ. கைப்பேசி உபயோகித்துக்கொண்டு வாகனம் ஓட்டுவது

ஈ. தேசிய நெடுஞ்சாலையில் வாகனம் ஓட்டுவது

2. நீங்கள் இருசக்கர வாகனம் ஓட்டும்பொழுது எந்த காரணத்திற்காக தண்டிக்கப்படுவீர்கள்

அ. ஓட்டுநர் உரிமம் இல்லாமல் வாகனம் ஓட்டுவது

ஆ. இரண்டு பேர் வாகனத்தில் செல்வது

இ. வாகனம் ஓட்டும் பொழுது வளைவில் முந்துவது

ஈ. மலைபகுதியில் வாகனம் ஓட்டுவது

3. இருசக்கர வாகனம் ஓட்டும்பொழுது எந்த செயல்பாடு மரணத்தை விளைவிக்க கூடியது

அ. வாகனம் ஓட்டும்பொழுது கைபேசி உபயோகப்படுத்துவதால்

ஆ. இருவழிப்பாதையில் வாகனம் ஓட்டுவதால்

இ. நண்பர்களுடன் வாகனம் ஓட்டுவதால்

ஈ. மெதுவாக வண்டி ஓட்டுவதால்

4. தலைகவசம் அணியாமல் வாகனம் ஓட்டுவதால் ஏற்படுவது

அ. அதிக ஒலி பிரச்சனை

ஆ. மூச்சுதிணறல்

இ. தலையில் பலத்த அடி

ஈ. பொருட்களை பார்ப்பது கடினம்

5. புகைப்பிடிப்பதினால் ஏற்படுவது

அ. நுரையீரல் புற்றுநோய்

ஆ. தலைவலி

இ. வயிற்றுவலி

ஈ. கல்லீரல் நோய்

6. புகையிலை பயன்படுத்துவதினால் ஏற்படுவது

அ. சிறுநீரக கோளாறு

ஆ. பசியின்மை

இ. பார்வை கோளாறு

ஈ. வாய் புற்றுநோய்

7. பொது இடத்தில் புகைப்பிடிப்பது நமது நாட்டில் சட்டப்படி குற்றம்

அ. சரி

ஆ. தவறு

8. எது அதிக அளவு ஆல்கஹால் கொண்ட மதுபானம்

அ. பீர்

ஆ. ஒய்ன்

இ. பிராந்தி

ஈ. கல்

9. மதுஅருந்திவிட்டு இருசக்கர வாகனம் ஓட்டுவதால் ஏற்படுவது

அ. சாலைவிபத்து

ஆ. உடல்வலி

இ. உயர் இரத்த அழுத்தம்

ஈ. பார்வை கோளாறு

10. நீண்டநாட்கள் மதுஅருந்துவதினால் ஏற்படுவது

அ. கால்வலி

ஆ. போதைக்கு அடிமையாதல்

இ. நுரையீரல் புற்றுநோய்

ஈ. மூட்டுதேய்மான நோய்

11. நீண்டநாட்களுக்கு மதுஅருந்துவதினால் அதிகமாக பாதிக்கப்படும் உடல் உறுப்பு

அ. கல்லீரல்

ஆ. சிறுநீரகம்

இ. கணையம்

ஈ. நுரையீரல்

12. பள்ளியில் குற்றமான செயல்பாடு எனக்கருதுவது

அ. பள்ளிக்கு கூர்மையான ஆயுதங்களை எடுத்து செல்வது

ஆ. பள்ளிக்கு கூர்மையான பேனா எடுத்து செல்வது

இ. பள்ளியில் பெண்களுடன் பேசுவது

ஈ. நண்பர்களுடன் பேசுவது

13. பள்ளியில் மற்றொரு மாணவரை தாக்குவது குற்றமான செயல்பாடு

அ. சரி

ஆ. தவறு

14. அபாயகரமான செயல்பாடுகளில் ஈடுபடுவதால் கொடுக்கப்படும் தண்டனை

அ. சிறுவர் சீர்திருத்த பள்ளியில் அனுமதிப்பது

ஆ. தனிமைப்படுத்துதல்

இ. அபராதம் விதிப்பது

ஈ. பாடத்தில் மதிப்பெண்களை குறைத்தல்

15. தற்கொலை முயற்சியில் ஈடுபடுவது நமது நாட்டில் சட்டப்படி குற்றமாகும்

அ. சரி

ஆ. தவறு

16. தற்கொலை முயற்சி ஈடுபடுவதற்கான அறிகுறி

அ. மனதளவில் பாதிக்கப்படுவதால்

ஆ. பசியின்மை

இ. கோபம்

ஈ. தலைவலி

17. தற்கொலை முயற்சி ஈடுபடுபவருக்கு கொடுக்கப்படும் தண்டனை

அ. சிறைத்தண்டனை குறைந்த பட்சம் 1 வருடம்

ஆ. பத்து இலட்சம் அபராதம்

இ. தனிமைப்படுத்துவது

ஈ. ஏதுமில்லை

18. எய்ட்ஸ் வருவதற்கான காரணம்

அ. எய்ட்ஸ் பாதிக்கப்பட்டவர்களுக்கு முத்தம் கொடுப்பதினால்

ஆ. எய்ட்ஸ் பாதிக்கப்பட்டவரை அணைப்பதினால்

இ. எய்ட்ஸ் பாதிக்கப்பட்வருடன் உடலுறவு கொள்வதினால்

ஈ. மேற்கூறிய எதுவும் இல்லை

19. எச்.ஐ.வி கிருமி பரவும் முறை

அ. இரத்தம்

ஆ. விந்து

இ. பிறப்புறுப்பு திரவம்

ஈ. மேற்கூறிய அனைத்தும்

20. உடலுறவு மூலம் பரவும் நோயை தடுக்கும் முறை

அ. உடலுறவிற்கு பின் பிறப்புறுப்புக்களை சுத்தம் செய்வது

ஆ. பாதுகாப்பு உறை அணிவது

இ. நோய் தடுக்கும் மருந்து எடுத்துக்கொள்வது

ஈ. கர்ப்பத்தை தடுக்கும் மருந்து எடுத்துக்கொள்வது

21. சிறுவயதில் கர்ப்பம் ஆவதற்கான காரணம்

அ. பாதுகாப்பு இல்லாமல் உடலுறவு கொள்வதினால்

ஆ. கர்ப்பம் தடுக்கும் மாத்திரை உபயோகபடுத்தாதலால்

இ. கர்ப்பம் தரித்தல் பற்றிய குறைந்த அறிவு

ஈ. மேற்கூறிய அனைத்தும்

22. எய்ட்ஸ் குணப்படுத்தக்கூடிய நோய்

அ. சரி

ஆ. தவறு

23. போதை ஊசிகளை மற்றவர்களுடன் பகிர்ந்துகொள்வதால் ஏற்படுவது

அ. மஞ்சள்காமாலை மற்றும் எய்ட்ஸ்

ஆ. நுரையீரல் பாதிப்பு

இ. பார்வை கோளாறு

ஈ. மேற்கூறிய எதுவும் இல்லை

24. போதை பொருள் பயன்படுத்துவதினால்

அ. போதைக்கு அடிமையாதல்

ஆ. வைட்டமின் குறைபாடு

இ. உடல்பருமன் அதிகரிப்பது

ஈ. தலைச்சுற்றல்

25. நமது நாட்டில் தடைசெய்யப்பட்ட போதைபொருள்

அ. கஞ்சா

ஆ. ஹெராயின்

இ. கோகைன்

ஈ. மேற்கூறிய அனைத்தும்

26. ஹெராயின் போதை பொருள் பயன்படுத்துவது நம் நாட்டில் சட்டப்படிகுற்றமாகும்

அ. சரி

ஆ. தவறு

27. உடல் பருமனால் ஏற்படுவது

அ. இருதய கோளாறு

ஆ. கல்லீரல் பாதிப்பு

இ. சிறுநீரக பாதிப்பு

ஈ. கணைய புற்றுநோய்

28. அதிக அளவு கொழுப்பு சத்து கொண்ட உணவு

அ. நெய்

ஆ. பால்

இ. மோர்

ஈ. தயிர்

29. உடல்பருமன் அதிகரிப்பதற்கான காரணம்

அ. ஊக்கம் குறைந்த செயல்பாடு

ஆ. அதிக பழங்கள் உண்பது

இ. அதிக காய்கறிகள் உண்பது

ஈ. மேற்கூறிய எதுவும் இல்லை

30. உடல்பருமனை தடுப்பதற்கான வழிமுறைகள்

அ. அதிக நார்ச்சத்து கொண்ட உணவை எடுத்துக்கொள்வது

ஆ. உடற்பயிற்சி

இ. கொழுப்புசத்து அல்லாத உணவை உட்கொள்வது

ஈ. மேற்கூறிய அனைத்தும்

பகுதி – 3

மதிப்பீட்டு விடைகள்

கேள்வி எண்	விடை	கேள்வி எண்	விடை
1	ஆ	16	அ
2	ஆ	17	அ
3	ஆ	18	இ
4	இ	19	ஆ
5	அ	20	ஆ
6	ஈ	21	ஈ
7	அ	22	ஆ
8	இ	23	அ
9	அ	24	அ
10	ஆ	25	ஈ
11	அ	26	அ
12	அ	27	அ
13	அ	28	அ
14	அ	29	அ
15	அ	30	ஈ

HIGH RISK BEHAVIOUR AND ITS PREVENTION

STUDENT PROFILE

Course	:	M.sc (N) II year
Subject	:	Mental Health Nursing
Topic	:	High risk behaviour and its prevention
Group	:	Higher secondary standard
Venue	:	Government Higher Secondary School, Acharapakkam.
Duration	:	45 min
Student teacher	:	S.KARTHIK
Method of teaching	:	Lecturer cum discussion
A.V.aids	:	Chart, Poster and Handout

CENTRAL OBJECTIVE:

Help the students to acquire adequate knowledge about " high risk behaviour and its prevention" and to develop desirable attitude, skills apply this in all health care and community settings.

CONTRIBUTORY OBJECTIVE:

The student will able to

- define high risk behavior
- enlist the type of high risk behaviour
- state the prevalence of high risk behaviour
- mention the risk factors of high risk behaviour
- enumerate the effects of high risk behaviour
- explain the management of high risk behaviour
- describe the offences related to high risk behaviour

S.NO	CONTRIBUTORY OBJECTIVE	TIME	CONTENT	TEACHERS ACTIVITY	LEARNERS ACTIVITY
1.	define high risk behavior	3min	**INTRODUCTION:** High-risk behaviors are those that can have adverse effects on the overall development and well-being of youth, or that might prevent them from future successes and development. This includes behaviors that cause immediate physical injury (e.g., fighting), as well as behaviors with cumulative negative effects (e.g., substance use). Risk behaviors also can affect youth by disrupting their normal development or prevent them from participating in 'typical' experiences for their age group. **DEFINITION :** It is a behavior that puts you at risk for a bad consequence. An example is smoking puts you at risk for cancer, being overweight puts you at risk for a heart attack, breaking the	explaining	listening

			law puts you at risk for going to jail, and so on.		
2.	Enlist the types of high risk behavior	10min	**COMMON TYPES OF HIGH RISK BEHAVIOURS:** Of the many risky behaviors in which teens tend to participate, the following are probably the most common: 1. Underage drinking 2. Drug use and abuse 3. Smoking 4. Unprotected sex 5. Excessive dieting and/or eating disorders 6. Unsafe driving (under the influence or on cell phones,) 7. Self-injuries, violence and suicide	explaining	listening
3.	state the prevalence of high risk behavior	5min	**Prevalence of High-Risk Behaviors** Several high-risk behaviors have been of particular interest to professionals because of their prevalence in youth today. Many of these behaviors cause a large number of	explaining	listening

			deaths and injury among teens, or have negative impacts on society. Alcohol is an important factor in approximately 41% of all deaths from motor vehicle crashes . Among youth, the use of alcohol and other drugs has been linked to unintentional injuries, physical fights, academic and occupational problems, and illegal behavior. In India the prevalence of alcohol in rural and urban community among adolescents were found to be 7.37% and 5.23%. Next to alcohol use the trend of illicit drug use is slowly increasing among adolescents of our country, the prevalence for it ranges between 6.14% and 0.6% in rural and urban community. In India current suicide rate of 10.5/1 000 000 About 35% of suicides occur amongst youth (15–29 years). The magnitude of overweight ranges from 9% to 27.5% and obesity ranges from 1% to 12.9% among Indian children.		

4.	Mention the risk factors of high risk behaviours	5min	**Risk Factors** Scholars have identified several factors that predispose youth to risk behaviors. At the individual level, youth who have low self-esteem, who have negative peer groups, and low school engagement or educational aspirations are more likely to engage in risky behaviors. Familial factors include poor parent-child communication, low parental monitoring (e.g., parents are unaware of youth's whereabouts), and a lack of family support. Not surprisingly, when parents themselves engage in risky behaviors, teens also are more likely to do so. Finally, extra-familial variables also play a role in the risk behaviors of youth. Negative school climate, poor neighborhood quality and low socioeconomic status, and poor (or no) relationships with non-parental adults also are at more risk for negative behaviors.	explaining	listening

5.	enumerate the effects of risk behaviors	15min	**EFFECTS OF RISK BEHAVIOURS:** **Psychological Effects of Alcoholism** There are four progressive stages of alcoholism. At each stage of the disease, the alcoholic manifests increasingly worse consequences than the previous stage. however, the following list will be presented as a combination or a collective of the different psychological effects of alcoholism that are common to the disease, regardless of the stage at which they usually occur: • Self-centeredness • Cloudy thinking • Self-pity • Boasting and a "big shot" complex	explaining	listening

			• Stress • Discontentment • An increase in failed promises and resolutions to one's self and to others • Anxiety • Moral deterioration • Dysthymia (mild chronic depression) • Lack of recognition by the person that he or she has a progressive illness • Obsession with drinking • Restlessness • Fearful • Loss of interests • Unreasonable resentments		

			• Loss of willpower • Irritability • Aggression • Sleep problems • Poor concentration • Feeling useless • The development and the later collapse of an alibi system. • Depression • Loss of control • Resentment • Denial of the effects of alcohol **Physical Effects Of Alcohol** The physical effects of alcohol are many and far reaching and they can vary		

			from person to person. These physical effects can be mild but many of them can be very dangerous. • Alcohol impacts directly on the chemistry and physical makeup of the brain. It acts as a depressant and destroys brain cells each time a person has a drink. • Other symptoms are faulty muscle control, impaired coordination, slurring of speech, and poor judgment. • In the long term drinking alcoholically can lead to a condition know as 'Wet Brain' (Wernicke-Korsakoff Syndrome). People with this condition often display extreme confusion and dementia like symptoms. • Another of the physical effects of alcohol can be damage to the liver. Liver disease is often directly related to long-term alcohol use. • There is also a condition known as		

			alcoholic hepatitis that can occur and this is due to damage to the liver from alcohol. • The pancreas is also directly affected by alcohol. Pancreatic disease is very common in those with alcohol problems. • Pregnant women need to be aware of the results alcohol can have on their unborn child. Alcohol can damage a foetus and can lead to spontaneous abortion or the birth of a child with permanent brain damage. • One other physical effect of alcohol involves nausea and vomiting Alcohol can erode the lining of the stomach and this may lead to nausea and vomiting. **Social Effects of Alcoholism :** There are also social effects of alcoholism that are very much related to the psychological effects of alcoholism. The following represents some of the social effects of alcoholism:		

			• Blaming problems on others and on things external to themselves • Withdrawal from social activities • Devaluation of personal relationships • Legal problems • Withdrawal from family and friends • Difficulties performing at work or home • Difficulties and arguments with family or friends • Financial insecurity • Serious relationship and work-related problems • Unemployment **Psychological effects of smoking:** Once a person becomes addicted to cigarettes, they may find themselves experiencing different withdrawal symptoms when they decide to stop. These withdrawal symptoms include: • increased nervousness and tension • agitation • loss of concentration • change in sleep patterns • headaches		

			• coughs • strong cravings **Physical effects of smoking:** The effects of smoking varies from person to person as it will depend on the person's vulnerability to the chemical in cigarette or tobacco smoke. Immediate effects upon smoking a cigarette stick: • Raises a person's blood pressure and heart rate. • Decreases a person's blood flow to body extremities like the fingers and toes. • The brain and the nervous system is stimulated for a short time and then reduced. • Dizziness. • Nausea. • Watery eyes. • Hyperacidity. • Weakened sense of taste and smell. • Loss of appetite. Other effects: • Shortness of breath.		

			• Chronic coughing. • Reduced overall fitness. • Yellowish stain on the smoker's fingers and teeth. • Smokers experience more coughs and colds as compared to non-smokers. • Difficulty recovering from minor illnesses. • Impotence for men, infertility for women. • Facial wrinkles appear at an early age, making them look older than non-smokers of the same age. Because they experience these different side effects, they have a higher risk of developing diseases like: • respiratory tract infections (like pneumonia and chronic bronchitis) • emphysema (collapse of the small airways in the lungs) • heart attack and other coronary diseases • different kinds of cancers (lungs, throat, mouth, bladder, kidney, pancreas, cervix, and stomach) • stomach ulcers		

			• peripheral vascular disease due to a decreased blood flow to the legs **Tobacco: psychological effects.** Tobacco's nicotine affect the brain's dopamine levels, the molecule of pleasure and mimics other neurotransmitters(**acetylcholine**) affecting mood, appetite, and memory. (Read Tobacco brain effects section) Once the brain is accustomed to a certain level of nicotine, it will claim more as the levels drop.(Read Tobacco addiction section) **Tobacco: physical effects.** Nicotine affects the entire body. Nicotine acts directly on the heart to change heart rate and blood pressure. It also acts on the nerves that control respiration to change breathing patterns. In high concentrations, nicotine is deadly, in fact one drop of purified nicotine on		

			the tongue will kill a person. As tobacco reduces the amount of oxygen to the brain and muscles, it is responsible for **headaches**, "**vertigos**", and **diminishes exercise endurance**. The long term physical effects of tobacco are devasting **leading to certain death** caused by: • **Coronary** linked problems • **Lungs** linked problems **Health effects of Obesity**: • Type 2 DM • Heart disease • Stroke • High blood pressure (hypertension) • High cholesterol • Certain cancers • Sleep apnea • Osteoarthritis • Gall bladder disease and gallstones • Fatty liver disease		

			• Gastro esophageal reflux disease • Gout **Psychological and emotional effects.** perceive themselves as physically unattractive believe that others make disparaging comments about their weight dislike being seen in public feel discrimination when applying for jobs. **EFFECTS OF UNPROTECTED SEX:** **Psychological effects :** Fears, panic attacks, sleeping problems, nightmares, irritability, outbursts of anger and sudden shock reactions when being touched. Little confidence, and self-respect and respect		

6.	explain the		for one's own body may change. Behavior that harms the body: addiction to alcohol and other substances, excessive work or sports, depression, self-destruction and prostitution. **PHYSICAL COMPLAINTS:** Abdominal pain, pain while making love, menstrual pain, intestinal complaints, stomach ache, nausea, headache, back pain, painful shoulders, in short all kinds of chronic pain may occur. The pain is often inexplicable. **Social problems:** Have little confidence in other people. Fear of loss of control in relationships. **Academic Performance** Poor academic performance among school students is associated with alcohol consumption. Alcohol abuse contributes to students missing class, failing		

	management of high risk behavior	15min	tests, dropping out due to do poor grades, and compromising the academic mission of schools. **MANAGEMENT:** • Healthy living facts • Eating (diet) • Physical activity and exercise • Group activity • Avoid tobacco use • Avoid excessive alcohol consumption • Avoid high-risk sexual behaviors • Avoid other high-risk behaviors • Additional tips for healthy living **Healthy living facts** Healthy living" to most people means both physical and mental health are in balance or functioning well together in a person. In many instances, physical and mental health are closely linked, so that a change (good or bad) in one directly affects the other. Consequently, some of the tips will include suggestions for	explaining	listening

			emotional and mental "healthy living." **Eating (diet)** All humans have to eat food for growth and maintenance of a healthy body, but we humans have different requirements as infants, children (kids),teenagers, young adults, adults, and seniors Tips: • Eat three meals a day (breakfast, lunch, and dinner); it is important to remember that dinner does not have to be the largest meal. • The bulk of food consumption should consist of fruits, vegetables, whole grains, and fat-free or low-fat milk products. • Choose lean meats, poultry, fish, beans, eggs, and nuts (with emphasis on beans and nuts). • Choose foods that are low in saturated fats, trans fats, cholesterol, salt (sodium), and added sugars; look at the labels because		

			the first listed items on the labels comprise the highest concentrations of ingredients. • Snacks are OK in moderation and should consist of items like fruit, whole grains, or nuts to satisfy hunger and not cause excessive weight gain. • Avoid sodas and sugar-enhanced drinks because of the excessive calories in the sodas and sugar drinks; diet drinks may not be a good choice as they make some people hungrier and increase food consumption. • Avoid eating a large meal before sleeping to decrease gastro esophageal reflux and weight gain. • Avoid sugary snacks; • Avoid heavy meals in the summer months, especially during hot days. • A vegetarian lifestyle has been promoted for a healthy lifestyle and weight loss; vegetarians should check with their physicians to be sure they are getting enough vitamins, minerals, and iron in their		

			food. • Avoid eating raw or undercooked meats of any type. **Physical activity and exercise** Physical activity and exercise is a major contributor to a healthy lifestyle; people are made to use their bodies, and disuse leads to unhealthy living. Unhealthy living may manifest itself in obesity, weakness, lack of endurance, and overall poor health that may foster disease development. Tips: • Regular exercise can prevent and reverse age-related decreases in muscle mass and strength, improve balance, flexibility, and endurance, and decrease the risk of falls in the elderly. Regular exercise can help prevent coronary heart disease, stroke, diabetes, obesity, and high blood pressure. Regular, weight-bearing exercise can also help prevent		

			osteoporosis by building bone strength. • Regular exercise can help increase self-esteem and self-confidence, decrease stress and anxiety, enhance mood, and improve general mental health. • Regular exercise can help control weight gain and in some people cause loss of fat. • Thirty minutes of modest exercise (walking is OK) at least three to five days a week is recommended, but the greatest health benefits come from exercising most days of the week. • Exercise can be broken up into smaller 10-minute sessions. • Almost any type of exercise (resistance, water aerobics, walking, swimming, weights, yoga, and many others) is helpful for everybody. • Sports for children may provide excellent opportunities for exercise, but care must be taken not to overdo certain exercises (for example, throwing too many pitches in baseball may harm a joint like the elbow or		

			shoulder). • Exertion during strenuous exercise may make a person tired and sore, but if pain occurs, stop the exercise until the pain source is discovered; the person may need to seek medical help and advice about continuation of such exercise. **Group activity:** It combains play and talk about the activity. So, they learns social skills by talking turns and sharing peers. **Mental health** Healthy living involves more than physical health, it also includes emotional or mental health. The following are some ways people can support their mental health and well-being. Tips: • Get enough sleep daily; the CDC recommends the eight and a half to nine and a half hours for 10-17 years of age and		

			those 18 and above need seven to nine hours of sleep. • Try something new and often (eat a new food, try a different route to work, go to a new museum display). • Do some mind exercises (read, do a puzzle occasionally during the week). • Try to focus on a process intensely and complete a segment of it over one to several hours, then take a break and do something relaxing (walk, exercise, short nap). • Plan to spend some time talking with other people about different subjects. • Try to make some leisure time to do some things that interest you every week (hobby, sport). • Learn ways to say "no" when something occurs that you do not want to do or be involved with. • Have fun (go on a trip with someone you love, go shopping, go fishing; do not let		

			vacation time slip away). • Let yourself be pleased with your achievements, both big and small (develop contentment). • Have a network of friends; those with strong social support systems lead healthier lives. • Seek help and advice early if you feel depressed, have suicidal thoughts, or consider harming yourself or others. **Encourage participation in positive activities.** One effective way of discouraging engagement in negative behaviors is to encourage participation in positive activities. Today, there are many activities that teens can be involved in which encourage the development of various competencies and are enjoyable. If teens develop a sense of competency in acceptable activities, they will feel worthy and accepted. In feeling competent, teens likely will have fun and		

			reduce stress. **Avoidance behavior** is another key to healthy living. Below are described some of the major items to avoid if a person is seeking a healthy lifestyle. **Avoid tobacco use** Tip: • Stop smoking tobacco; start to stop today (it takes about 15 years of nonsmoking behavior to achieve a "normal" risk level for heart disease for those that smoke). • Stop using chewing tobacco to avoid oral cancers. **Comments and recommendations (tips):** • Quitting smoking is difficult to accomplish; tobacco contains nicotine, which is addictive. Some smokers can quit "cold turkey," but for most, quitting smoking requires a serious life-long commitment and		

			an average of six quitting attempts before success. • Quitting smoking efforts may include behavior modification, counseling, use of nicotine chewing gum (Nicorette Gum), nicotine skin patches (Transderm Nicotine), or oral medications such as bupropion (Zyban) **Avoid excessive alcohol consumption** **Comments and recommendations (tips):** There are many treatments for alcoholism. But the crucial first step to recovery is for the individual to admit there is a problem and make a commitment to address the alcoholism issue. The 12-step-style self-help programs, pioneered by Alcoholics Anonymous, can be one effective treatment. Psychologists and related professionals have developed programs to help individuals better handle emotional stresses and avoid behaviors that can lead to excess drinking. Support and understanding		

			from family members are often critical for sustained recovery. Medication can be useful for the prevention of relapses and for withdrawal symptoms following acute or prolonged intoxication **Avoid high-risk sexual behaviors** High-risk sexual behavior can lead to the acquisition of sexually transmitted illnesses, or HIV infection. **Recommendations (tips):** • Avoid unprotected sex (sex without barriers such as a condom) outside an established, committed, monogamous relationship. • If you plan to have sex and are unsure of your partner's health status, use a condom. **Avoid other high-risk behaviors** • Driving under the influence of alcohol or drugs		

7.	Describe the offences of high risk behaviours	15min	• Driving while sleep-deprived • Reckless driving and speeding, "road rage" • Driving while using cell phones, texting, or performing other tasks • Motorcycle riding without helmets • Smoking in bed **Recommendations (tips):** • Do not drink and drive. • Do not drive if sleep deprived. • Avoid unnecessary distractions and focus on the road and traffic while driving (avoid texting, talking on cell phones, eating, applying makeup, or other distractions). • Use helmets while riding motorcycles. Helmet use reduces deaths from motorcycle accidents by 30% and serious head injuries by 75%. • Follow the traffic rules. **Minimum Legal Drinking Age** The minimum legal drinking age (MLDA), also	explaining	listening

			referred to as the Age 21 laws, refers to the Uniform Drinking Age Act of 1984. While state laws set the legal drinking age in their own jurisdictions, the Uniform Drinking Age Act encouraged states to set the age at 21 by restricting federal transportation funds from those states that maintained a lower drinking age. **Offences related driving** Driving by minor, maximum penalty Rs.500,under the section 4r/w 177 MVA. Driving without helmet, penalty Rs.100,under the section 129 r/w 177 MVA. **Conclusion** Adolescence is a unique period of the lifespan. It is full of changes and challenges, but also of growth and opportunities. Adolescents are particularly susceptible to high-risk behaviors so concerned adults need		

			to support youth as they go through this period.		

அபாயகரமான செயல்பாடுகள்

மற்றும்

தவிர்க்கும் வழிமுறைகள்

அபாயகரமான செயல்பாடுகள் மற்றும்
தவிர்க்கும் வழிமுறைகள்

மத்திய நோக்கங்கள்

உயர்நிலை மற்றும் மேல்நிலைப் பள்ளியில் பயிலும் மாணவர்களுக்கு அபாயகரமான செயல்பாடுகள் மற்றும் அதனை தவிர்க்கும் வழிமுறைகளைப் பற்றி விவரித்தல்.

குறிப்பிட்ட நோக்கங்கள்

- அபாயகரமான செயல்பாடுகளின் வரையறை
- அபாயகரமான செயல்பாடுகளின் வகைகள்
- அபாயகரமான செயல்பாடுகளைப் பற்றிய புள்ளி விவரம்
- அபாயகரமான செயல்பாடுகளின் காரணிகள்
- அபாயகரமான செயல்பாடுகளை தவிர்க்கும் வழிமுறைகள்
- சட்டங்கள்

வ.எண்	நேரம்	மத்திய நோக்கங்கள்	பொருளடக்கம்	ஆசிரியர் கற்பித்தல்	மாணவர் கவனித்தல்
1.	5 நிமிடம்	அபாயகரமான செயல்பாடுகளின் வரையறை	**முன்னுரை** அபாயகரமான செயல்பாடுகள் இளைஞர்களின் ஒட்டுமொத்த வளர்ச்சியையும், உடல்நலனையும் மற்றும் எதிர்காலத்திட்டத்தையும் பாதிக்கின்றது. மதுப்பழக்கம், புகைப்பழக்கம், போதைப் பழக்கம், சண்டை, கட்டுப்பாடற்ற உணவு பழக்கம், பாதுகாப்பற்ற உடலுறவு ஆகியவை அபாயகரமான செயல்பாடுகள் ஆகும். **வரையறை** அபாயகரமான செயல்பாடுகள் என்பது இளைஞர்களை மோசமான விளைவுகளை சந்திக்க வைக்கும் ஒரு நிகழ்வு ஆகும். எ.கா. புகைபழக்கம் மற்றும் போதைப்பழக்கம் புற்றுநோயை உண்டாக்குகிறது. மற்றும் சட்டச் சிக்கல்களையும் ஏற்படுத்துகிறது.	விவரித்தல்	கவனித்தல்
2.	5 நிமிட	அபாயகரமான செயல்பாடுகளின்	**அபாயகரமான செயல்பாடுகளின் வகைகள்** 1. மதுப்பழக்கம் 2. போதைப்பழக்கம்	விவரித்தல்	கவனித்தல்

	ம்	வகைகள்	**3.** புகைப்பழக்கம் **4.** பாதுகாப்பற்ற உடலுறவு **5.** கட்டுபாடற்ற உணவுபழக்கம் **6.** பாதுகாப்பற்ற பயணம் **7.** வன்முறை மற்றும் தற்கொலை முயற்சி		
3.	5 நிமிடம்	அபாயகரமான செயல்பாடுகளைப் பற்றிய புள்ளி விவரம்	**நிகழ்வு** உலகம் முழுவதும் மது அருந்திவிட்டு வாகனம் ஓட்டுவதால் ஏற்படும் உயிரிழப்பு **41** சதவிகிதம் ஆகும். மேலும் இந்த செயல்பாடு இளைஞர்களை சட்டசிக்கல்களிலும், கல்வித்திறனையும் பாதிக்கிறது. இந்தியாவில் மதுபழக்கம், புகையிலை பயன்படுத்தும் இளைஞர்களின் எண்ணிக்கை கிராமப்புரத்தில் 5.23% நகர்புறத்தில் **7.37** சதவிகிதம் ஆகும். தற்கொலை முயற்சியில் ஈடுபடும் இளைஞர்களின் எண்ணிக்கை **10.5** சதவிகிதம் கட்டுப்பாடற்ற உணவு பழக்கத்தினால் உடல்பருமன் அதிகரிக்கும் இளைஞர்களின் எண்ணிக்கை 12.9%	விவரித்தல்	கவனித்தல்
4.	15 நிமிடம்	அபாயகரமான செயல்பாடுகளின் காரணிகள்	**அபாயகரமான செயல்பாடுகளின் காரணிகள்** **1.** குடும்ப பொருளாதார நிலை **2.** தவறான நண்பர்களின் பழக்கவழக்கம் **3.** கல்வியில் ஆர்வமின்மை	விவரித்தல்	கவனித்தல்

			4. குறைந்த சுயமரியாதை 5. பெற்றோர்களின் கவனமின்மை **அபாயகரமான செயல்பாடுகளின் விளைவுகள்** 1. மதுப்பழக்கத்தினால் ஏற்படும் விளைவுகள் **மன உளவியல் பாதிப்புகள்** ➢ மன அழுத்தம் ➢ மன அதிருப்தி ➢ தவறான வாக்குறுதிகள் ➢ ஆர்வமின்மை ➢ அமைதியின்மை ➢ பயம் ➢ ஒழுக்கமின்மை ➢ தூக்கப் பிரச்சினைகள் ➢ ஞாபகமின்மை **உடல்விளைவுகள்** ➢ தவறான தசை கட்டுபாடு ➢ பலவீனமான பேச்சுவார்த்தை ➢ கல்லீரல் பாதிப்பு ➢ மஞ்சள்காமாலை ➢ கணைய பாதிப்பு		

			➢ இரைப்பை புற்றுநோய் ➢ மூளை செல்பாதிப்பு ➢ சிறுநீரக பாதிப்பு ➢ வாந்தி குமட்டல் **புகைப்பழக்கத்தினால் ஏற்படும் விளைவுகள்** **மணஉளவியல் பாதிப்புகள்** ➢ பதற்றம் ➢ கிளர்ச்சி ➢ கவனமின்மை ➢ தூக்கமின்மை **உடல் விளைவுகள்** ➢ உயர் இரத்த அழுத்தம் ➢ இதயதுடிப்பு அதிகரித்தல் ➢ தலைசுற்றல், தலைவலி ➢ பசியின்மை ➢ தொடர்ச்சியான இருமல் ➢ ஆண்மையின்மை ➢ இதயபாதிப்பு ➢ புற்றுநோய் (நுரையீரல், வாய், தொண்டை) **புகைப்பழக்கத்தினால் ஏற்படும் விளைவுகள்** **மனஉளவியல் பாதிப்புகள்**		

			➢ ஞாபகமின்மை ➢ நரம்பு மண்டலப் பாதிப்பு ➢ மனநிலை பாதிப்பு ➢ ஞாபகமின்மை **உடல்விளைவுகள்** ➢ உயர்இரத்த அழுத்தம் ➢ இதயநோய்கள் ➢ நுரையீரல் பாதிப்பு ➢ இரத்தத்தில் ஆக்ஸிஜன் குறைபாடு ➢ தலைவலி ➢ சுவாச கோளாறு **கட்டுபாடற்ற உணவு பழக்கத்தினால் ஏற்படும் மனஉளவியல் பாதிப்புகள்** ➢ தாழ்வு மனப்பான்மை ➢ உடல்பருமனால் வெளியே செல்லாதிருத்தல் ➢ உடல்பருமனை நினைத்து வருத்தப்படுதல் **உடல்விளைவுகள்** ➢ நீரிழிவு நோய் ➢ இதயநோய் ➢ பக்கவாதம்		

			➢ உயர்ரத்த அழுத்தம் ➢ கொழுப்பு அதிகரித்தல் ➢ புற்றுநோய்கள் ➢ மூட்டுவாத நோய் ➢ கொழுப்பு கல்லீரல் நோய் **பாதுகாப்பற்ற உடலுறவினால் ஏற்படும் விளைவுகள்** **மனஉளவியல் பாதிப்புகள்** ➢ மனஅழுத்தம் ➢ அச்சம் ➢ கோபம் ➢ எரிச்சல் **உடல்விளைவுகள்** ➢ எய்ட்ஸ் ➢ பால்வினை நோய் ➢ தலைவலி ➢ வயிற்று வலி **அபாயகரமான செயல்பாடுகளினால் ஏற்படும் சமூக விளைவுகள்** ➢ சட்டசிக்கல்கள் ➢ சமூக அக்கரையின்மை ➢ குடும்பத்திருந்து தனிமைபடுத்துதல்		

5.	*10* நிமிடம்	அபாயகரமான செயல்பாடுகளை தவிர்க்கும் வழிமுறைகள்	➢ வேலைத் தொடர்பான சிக்கல்கள் ➢ நிதிப்பற்றாக்குறை **கல்வியில் மாணவர்களின் செயல்பாடுகள்** ➢ பள்ளிக்கு சரியாக வராதிருத்தல் ➢ பரிட்சையில் குறைந்த மதிப்பெண்கள் ➢ கல்வியில் குறைந்த ஆர்வம் ➢ பள்ளிக்கு செல்லாதிருத்தல் **அபாயகரமான செயல்பாடுகளை தவிர்க்கும் வழிமுறைகள்** ➢ ஆரோக்கியமான வாழ்வு முறை ➢ சரிவிகித உணவு முறை ➢ உடற்பயிற்சி ➢ **கூட்டாக கலந்துரையாடல் ஆலோசனைகள்** **ஆரோக்கியமான வாழ்வு முறை** ஆரோக்கியமான வாழ்வு முறை என்பது உடல் மற்றும் மனநிலையைச் சார்ந்தது. இதில் ஏதேனும் மாற்றம் ஏற்பட்டால், இது அவர்களின் செயல்பாடுகளில் மாற்றத்தை ஏற்படுத்துகிறது. ஆரோக்கியமான சூழ்நிலை, உணவுமுறை, உறவுமுறை, கல்வி ஆரோக்கியமாக வாழ வழிவகுக்கிறது. **சரிவிகித உணவு** சரிவிகித உணவானது உடலை ஆரோக்கியமாகவும், உடல் எடையை கட்டுப்பாடாக வைக்கிறது.	விவரித்தல்	கவனித்தல்

			குறிப்புகள் தினமும் சரியான நேரத்திற்கு உணவு எடுத்துக்கொள்ள வேண்டும். இரவு உணவை பெரிய உணவாக இருக்க கூடாது தினமும் உணவில் அதிக அளவு முழு தானியங்கள், காய்கறிகள், பழங்கள், பால் பொருட்கள் சேர்த்து கொள்ள வேண்டும். மீன், இறைச்சி, முட்டை, ஆகிய உணவுப் பொருட்களை தேர்வு செய்யவும். உதிரிபண்டங்கள் அதிகமாக சேர்த்துக்கொள்ளக்கூடாது கொழுப்புச்சத்து அதிகம் உள்ளப் பொருட்களை சேர்த்துக் கொள்ளக்கூடாது **உடற்பயிற்சி** உடற்பயிற்சியானது ஆரோக்கியமாகவும், சுறுசுறுப்பாகவும் வாழ வழிவகுப்பதிலும் உடல் எடையை கட்டுப்பாடனும் மேலும் நோய்கள் வராமல் இருக்க தடுக்கிறது. **குறிப்புகள்** ➢ தினமும் உடற்பயிற்சி செய்வதால் இதயநோய், பக்கவாதம், உயர்இரத்த அழுத்தம், நீரிழிவு நோய் மற்றும் உடல் பருமனாவரை தடுக்கிறது. ➢ சீரான உடற்பயிற்சி மனவமை அதிகரிக்கிறது. மற்றும்		

			மனஅழுத்தத்தை குறைக்கிறது. **மனநலம்** மனநலத்துடன் வாழ உடல்நிலையும் மற்றும் சுற்றுப்புற சூழலும் முக்கிய வழிவகுக்கிறது **குறிப்புகள்** ➢ நாள் ஒன்றுக்கு குறைந்தபட்சம் 30 நிமிட உடற்பயிற்சி ➢ நாள் ஒன்றுக்கு 7–9 மணி நேரம் தூங்க வேண்டும் ➢ மூச்சு பயிற்சி ➢ மன வமை பயிற்சி ➢ நண்பர்களுடன் கலந்துரையாடல் ➢ விளையாட்டு மேற்கூறியவை யாவும் மன அழுத்தத்தையும் தற்கொலை எண்ணத்தை தவிர்த்து மனவமையுடன் வாழ வழிவகுக்கிறது. **கூட்டாக கலந்துரையாடல்** கூட்டாக கலந்துரையாடுவதால் மனவமையையும், அதிகரிப்பதுடன் மனஅழுத்தத்தையும் குறைக்கிறது. மேலும் இது படிப்பு, விளையாட்டு மற்றும் இதர துறைகளில் ஆர்வத்தை அதிகரிக்கிறது.		

6.	5 நிமிடம்	சட்டங்கள்	**சட்டங்கள்** ➢ IPC 1984 **சட்டப்படி இளைஞர் மது அருந்துவதற்கான வயது 21.** ➢ **ஓட்டுநர் உரிமம் இல்லாமல் வாகனம் ஓட்டும்போது, பிரிவு** 4R/W **மோட்டார் வாகன சட்டத்தின் கீழ் அபராதம் 500 விதிக்கப்படும்** ➢ **தலைகவசம் இல்லாமல் வாகனம் ஓட்டும் போது பிரிவு** 129 R/W **மோட்டார் வாகனச் சட்டத்தின் கீழ் 100 விதிக்கப்படும்.** **முடிவுரை** **இளமை பருவமானது பல சவால்களை எதிர்கொள்ளவும் இலட்சியங்களை அடைவதற்கான காலம். ஆசிரியர்களும், குடும்பத்தினரும் இளைஞர்களை ஊக்குவித்து அவர்களின் குறிக்கோள்களை அடைய வழிகாட்ட வேண்டும்.**	விவரித்தல்	கவனித்தல்

ANNEXURE

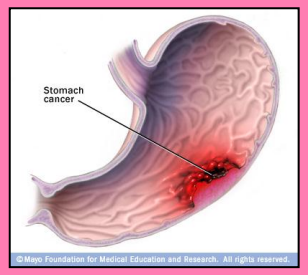
AUDIO VISUAL AIDS

HIGH RISK BEHAVIOURS

COMPLICATIONS OF SMOKING, ALCOHOLISM, TOBACCO USE AND ILLICIT DRUGS

ORAL CANCER

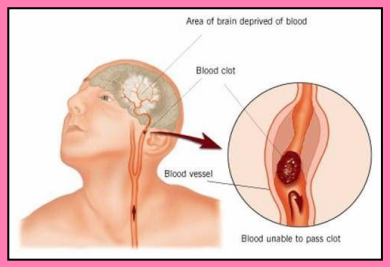
THROAT CANCER



STOMACH CANCER

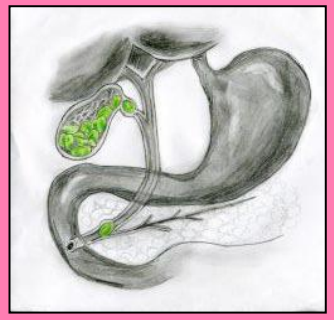
CIRRHOSIS OF LIVER

LUNG CANCER



STROKE

HEART ATTACK



GALL BLADDER DISEASES

VOMITING

STOMACH PAIN

COMPLICATIONS OF OBESITY, UNPROTECTED SEX AND DRIVING

- Diabetes mellitus
- Blood pressure
- Arthritis
- Heart diseases
- AIDS
- STD’s
- Severe head injury
- Multiple fracture
- Severe bleeding(internal or external)

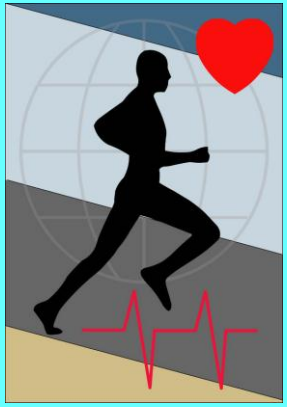
MANAGEMENT FOR HIGH RISK BEHAVIOURS

MEDITATION

EXERCISE

BALANCED DIET

GROUP PLAY



JOGGING

GROUP DISCUSSION

SCHOLAR, CONDUCTING PRETEST

SCHOLAR, CONDUCTING STRUCTURE TEACHING PROGRAMME

SCHOLAR, ENCOURAGE GROUP DISCUSSION

SCHOLAR, CONDUCTING POSTTEST